

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:
County Balto.
City or town Sparrow Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Shore Mill.
How long in hospital or institution? 18 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Balto.
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1553 Argyle Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Harry T. Armstrong

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Pearl Armstrong

7. Birth date of deceased (mo., day, yr.) 1894 6.(c) If alive, give age years

8. AGE: Years 51 Months Days If less than one day hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Bethlehem Steel Corp.

12. Name Harry Armstrong

13. Birthplace Md.

14. Maiden name I da M. Sewell

15. Birthplace Md.

16. Informant Pearl Armstrong

Address 1553 Argyle Ave

17. Burial Date thereof 10/19/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National

Location

18. Funeral director Ebroy C. Wilson

Address 1000 Brantley Ave

19. 10/19/45 19 Wm. Armstrong
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Oct 4 1945 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 1945 to Oct 4 1945 and that I last saw him alive on 19

Immediate cause of death Coronary Occlusion DURATION

Due to Voluntary Heart disease 1 yr.

Due to Chronic Bronchitis

Other conditions Acute Bronchitis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. Armstrong M.D.

Address Baltimore, Md. Date signed 10/19/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 16 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 730

CERTIFICATE OF DEATH

09767

Reg. Dist. No. 44

1. PLACE OF DEATH:
 County... Baltimore
 City or town... Edgemere
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
2401 Sparrows Point Road.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... md. County... Baltimore
 City or town... Edgemere
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2401 Sparrows Point Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William J. Armstrong

3. (b) Social Security Number

4. Sex... male 5. Color or race... white 6.(a) Single, married, widowed, or divorced... married
 6.(b) Name of husband or wife... Cora E. Armstrong
 7. Birth date of deceased (mo., day, yr.)... October 7, 1865 6.(c) If alive, give age... years
 8. AGE: Years... 79 Months... 11 Days... 27 If less than one day... hrs. min.

9. Birthplace... Baltimore, Md.
 (Town, county, and state)

10. Usual occupation... Retired Produce Dealer

11. Industry or business

12. Name... Daniel W. Armstrong

13. Birthplace... Md.

14. Maiden name... Helen E. Waterworth

15. Birthplace... Md.

16. Informant... Cora E. Armstrong

Address... 2401 Sparrows Point Rd.

17. Burial (Burial, cremation, or removal. Which?)... Burial Date thereof... Oct. 8, 1945
 (month) (day) (year)

Cemetery or crematory... Parkwood

Location... Taylor Ave., Parkville, Md.

18. Funeral director... John F. Genny, Inc.

Address... 715 Light St.

19. 10/8 19 45 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... October 4 19 45 at 8 30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 40 to Oct. 4 19 45
 and that I last saw him alive on October 1 19 45

Immediate cause of death... Chronic congestive heart failure
due to atherosclerotic heart disease
 DURATION... 2 yrs
15 yrs

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... A. W. Hedrick, M.D.
 M. D. or other

Address... 520 D St. Sp 17 19 Date signed... 10-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 DaysHospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, MarylandHow long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1709 Etting Street
(If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

3. (a) FULL NAME

ZEBEDEE ASHBY

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife..... Widowed7. Birth date of deceased (mo., day, yr.) 5-4-99

8. AGE: Years Months Days If less than one day

4658

.....hrs.min.

9. Birthplace..... Virginia
(Town, county, and state)10. Usual occupation..... Unemployed

11. Industry or business

12. Name..... Edward Ashby13. Birthplace..... Maryland

14. Maiden name..... ?

15. Birthplace..... Virginia16. Informant..... Clinical Records, Vets. Adm. Fac.Address..... Fort Howard, Md.17. Burial Date thereof..... 10-17-1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Baltimore National CemeteryLocation..... Baltimore, Maryland18. Funeral director..... MRS. George H. HollandAddress..... 1631 Druid Hill Ave. Balto., Md.19. (Date rec'd by registrar) Oct 17 1948 Registrar A.M. Balter

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 12, 1948 at 8:25 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 7, 1948 to October 12, 1948and that I last saw him alive on October 12, 1948

Immediate cause of death.....

Tuberculosis, chr. pul. far. adv.
active

DURATION

1 Month
plus

Due to.....

Due to.....

Other conditions..... Anemia, secondaryHypertension arterial

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... A.M. Balter MA.M. BALTER, LT.COL., M.C. CLIN. DIR.Address..... Fort Howard, Md. Date signed..... 10-13-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1642)

CERTIFICATE OF DEATH

09769

Reg. Dist. No.

1. PLACE OF DEATH:

County Balto.

City or town Glenan
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Glenan
(If outside city or town limits, write RURAL and give nearest town)

Street No. Harford Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Kramer Barnes.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

widowed.

6.(b) Name of husband or wife Mary C. Barnes

7. Birth date of deceased (mo., day, yr.) April 27th, 1868

8. AGE:

Years

Months

Days

If less than one day

77

5

4

hrs. min.

9. Birthplace Harford Co. Md.

(Town, county, and state)

10. Usual occupation Truck farmer

11. Industry or business

MOTHER

FATHER

12. Name Bennet Barnes

13. Birthplace Harford Co. Md.

14. Maiden name Namish J. Wills

15. Birthplace ecil Co. Md.

16. Informant Hatharine Hanch

Address 1506 Linden Ave

17. Burial Date thereof 10 8 45
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Parkwood

Location Balto City Md.

18. Funeral director Assault Funeral Home

Address 7401 Belair Rd.

19. (Date rec'd by registrar)

19

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1, 1945, at 12:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death

DURATION

Strangulation by hanging.

Med.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Suicide Date of 10/1/45

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Chas. F. Green Jr.

M. D. or other

Address Towson - 4 - Md Date signed 10/1/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 5 1945
BUREAU V. A.

COPY SENT TO Co. Health Officer 10/5/45
LOCAL REGISTRATION No. DATE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B2)

CERTIFICATE OF DEATH

09770

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
 City or town Rogers Forge, Balto. 12
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:
303 Regester Avenue
 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Rogers Forge, Balto. 12
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 303 Regester Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war -----

3. (a) FULL NAME

ANNIE PHIPPS BARWICK

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife John W. Barwick
 7. Birth date of deceased (mo., day, yr.) September 20, 18 1862
 8. AGE: Years 83 Months -- Days 25 If less than one day -- hrs. -- min.

9. Birthplace Long Green, Balto. Co., Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER 12. Name Robert E. Phipps
 13. Birthplace Maryland

MOTHER 14. Maiden name Mary Jane Phipps
 15. Birthplace Maryland

16. Informant Mrs. James Lowry
 Address 303 Regester Ave., Balto. 12 Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof OCT. 19 1945
 (month) (day) (year)
 Cemetery or crematory Prospect Hill Cemetery
 Location Towson, Maryland

18. Funeral director John Burnap Sons
 Address Towson, Maryland

19. Oct. 18 19 45 (Date rec'd by registrar) Registrar [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 19 45, at ----- M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5th 19 43, to Oct. 15 19 45
 and that I last saw her alive on Oct. 15 19 45

Immediate cause of death Myocardial Failure

Due to Arteriosclerosis
Cardio-Vascular Disease

Other conditions Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations -----

Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ----- Date of -----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE Dr. R. Sallace, M.D. M. D. or other -----

Address Towson 4, Md Date signed 10/15/45

RECEIVED
NOV 3 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md

CERTIFICATE OF DEATH

09771

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson, 4, Md.

How long in hospital or institution?

3. (a) FULL NAME

Marie Beelen

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 21, 1924

6. (c) If alive, give age years

8. AGE:

Years

21

Months

7

Days

6

If less than one day

hrs.min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Typist

11. Industry or business

FATHER

12. Name

Harry Beelen

13. Birthplace

Maryland

MOTHER

14. Maiden name

Emma Han

15. Birthplace

Maryland

16. Informant

Address

Personal History, Hospital Records
Eudowood Sanatorium, Towson Md.

17.

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

Date thereof

(month) (day) (year)

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

45Q.M. Bacon

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1945, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 25 1945 to Oct 27 1945and that I last saw him alive on Oct. 27 1945

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William A. Bridges
Towson, 4, Maryland

M. G. OTHER

Address

Date signed

RECEIVED

NOV 1 1945

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

09777230
Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1606 Bolton St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mary Gray Bentley

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 1, 1871
8. AGE: Years 73 Months 11 Days 9 If less than one day
hrs. min.

9. Birthplace Leesburg, Va.
(Town, county, and state)
10. Usual occupation retired

11. Industry or business

FATHER 12. Name Robert Bentley Jr.
13. Birthplace Va.
MOTHER 14. Maiden name Elizabeth Lee Cobell
15. Birthplace Va.

18. Informant Mrs. Elizabeth N. Pouder
Address 2 W. 39th. St.

17. Burial Date thereof Oct. 25, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Union Cemetery
Location Leesburg, Va.

18. Funeral director John O. Mitchell
Address 1900 Eutaw Place

19. 10/24/45 A. W. Heflich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1945 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 38 to Oct 22 19 45
and that I last saw her alive on Oct 21 19 45

Immediate cause of death Myocarditis
Arterio Sclerosis

DURATION

Gradual

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE W. N. Hoady M. D. or other

Address 1403 Park Ave Date signed 10/24/45

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 yrs

Hospital, institution, or street address where death occurred:

6300 Liberty Road

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Balto.

City or town..... Woodlawn
(If outside city or town limits, write RURAL and give nearest town)Street No..... 6300 Liberty Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Jeannette Ablett Boyd

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife..... Joseph Hillis Boyd

6. (c) If alive, give age..... 62 yrs

7. Birth date of deceased (mo., day, yr.) May 23, 1881

8. AGE: Years Months Days If less than one day
64 4 23 hrs. min.9. Birthplace..... Pittsburgh, Pa.
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name..... William Ablett

13. Birthplace..... Borne, England

14. Maiden name..... Margaret Fetzer

15. Birthplace..... Wheeling, W. Va.

18. Informant..... Mr. Joseph H. Boyd

Address..... 6300 Liberty Road, Woodlawn

17. Burial Date thereof..... Oct. 20, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Woodlawn Cemetery

Location..... Woodlawn, Md.

18. Funeral director..... H. C. Anderson

Address..... 4510 Liberty Heights Ave.

19. 10/20/45 H. C. Anderson
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 16 1945 at 1.15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1944 to Oct. 16 1945 and that I last saw her alive on Oct. 16 1945

Immediate cause of death..... 1) carcinoma of sigmoid colon
Due to..... secondary anemia

Due to..... Coronary Thrombosis

Major findings of operations..... carcinoma of sigmoid operatory Date of op..... May 1945

Autopsy results..... none
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE..... Carl L. Chambers M.D. or other

Address..... 4108 Liberty Hgts Ave. Date signed.....

RECEIVED
NOV 7 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

097774

Reg. Dist. No.

1. PLACE OF DEATH:
County..... Baltimore
City or town..... Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred
1720 Wilson Point Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Md County..... Baltimore
City or town..... Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1720 Wilson Point Road
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME Martha C. Brady 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
8. (b) Name of husband or wife Bernard
7. Birth date of deceased (mo., day, yr.) April 30 - 1892
8. AGE: Years 53 Months 5 Days 10 If less than one day hrs. min.

9. Birthplace..... Baltimore Md
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name.....

13. Birthplace..... Germany

14. Maiden name..... Anna E. Bachman

15. Birthplace..... Germany

16. Informant..... Bernard Brady

Address..... 1720 Wilson Point Road

17. Burial Date thereof..... Oct-23-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Schwartz

Location..... O'Donnell St.

18. Funeral director..... John C. Moran

Address..... 3000 E. Baltimore St.

19. 10/23/45 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 20 19..... 45 at 11:40 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 20 19..... 45 to Oct 20 19..... 45
and that I last saw him/her alive on Oct 20 19..... 45

Immediate cause of death..... Sudden Coronary DURATION..... 2 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Signature..... Wm. S. Gilroy M. D. or other

Address..... 677 Milled Ave Date signed..... Oct 20/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 88-2

CERTIFICATE OF DEATH

Reg. Dist. No. 09775 44

1. PLACE OF DEATH:

County BaltimoreCity or town Middle River, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balt.City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Alice Bredbeck BRENNEMAN

3. (b) Social Security Number

216.10.6870

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

Ben. Brenneiman

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Nov. 4 - 1886

8. AGE:

Years 58Months 11Days 6

If less than one day

_____ hrs. _____ min.

9. Birthplace

York Co. Pa.
(Town, county, and state)

10. Usual occupation

Santa Barbara

11. Industry or business

Walter aircraft

FATHER

12. Name

John M. Bredbeck -

13. Birthplace

Pa.

MOTHER

14. Maiden name

Alice Mordel -

15. Birthplace

Md.

16. Informant

Carle H. Brenneiman

Address

34 W. Green & Westminster

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 12, 1975
(month) (day) (year)

Cemetery or crematory

Lindbergh, Md.

Location

Lindbergh, Md.

18. Funeral director

Address

H. Seible
Glen Rock, Pa.

19.

(Date rec'd by registrar)

10/10

19.

45 John S. Corneley
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1945 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Cerebral HemorrhageDURATION
3 hrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

John S. Corneley
Registrar

Address _____

Date signed _____

DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

RECEIVED

OCT 18 1945

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore MD

09776

P

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Baltimore - 22.City or town... Dundalk.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yrs.Hospital, institution, or street address where death occurred: Box 283 Gletzer Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...

City or town... Asin # 1
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOSEPH IRVIN BROWN

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married.6. (b) Name of husband or wife... Martha BROWN.7. Birth date of deceased (mo., day, yr.) Nov 11. 1890.6. (c) If alive, give age 46. years

8. AGE:

Years

Months

Days

If less than one day

54115

hrs.

min.

9. Birthplace... Baltimore, Md.

(Town, county, and state)

10. Usual occupation... Contractor.11. Industry or business... Building.12. Name... Charles BROWN13. Birthplace... Germany.14. Maiden name... Mary Frailey.15. Birthplace... Kent Co. Md.16. Informant... Martha Brown.Address... Asin # 117. Burial Date thereof... 10/19/45

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory... Green Haven Cem.Location... Ritchie Highway18. Funeral director... John F. Fleming Inc.Address... 1501 Light St.19. Oct 16 45 A.W. Nedrich

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Oct. 16. 19 45. at 12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 45. to Oct. 16 19 45.and that I last saw him alive on Oct. 13 19 45.

Immediate cause of death

DURATION

Tuberculosis ofDue to... left hip29 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... Louis D. Tollin. M.D.Spawns Point 19. OCT 15 1945

Address... Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

097777 38
Reg. Dist. No.

1. PLACE OF DEATH: *Baltimore*
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*Md*..... County.....*Baltimore*.....
City or town.....*Ruxton*.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME *Louise Este Fisher Bruce* 3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*
6.(b) Name of husband or wife *Wm Cabell Bruce*

7. Birth date of deceased (mo., day, yr.) *Jan 10 1866* 6.(c) If alive, give age..... years

8. AGE: Years *79* Months *9* Days *12* If less than one day
..... hrs. min.

9. Birthplace.....*Baltimore Md*
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name *Wm Alexander Fisher*
13. Birthplace *Balto. Md*

MOTHER 14. Maiden name *Louise Este*
15. Birthplace *Cinn. Ohio*

16. Informant *Albert Cabell Bruce*
Address *107 E Oakcote Rd Balto 18*

17. *Cremation* Date thereof *Oct 22 1945*
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory *Green Mount Cem*
Location *Baltimore Md*

18. Funeral director *Henry W Jenkins & Sons*
Address *McCulloch & Orchard St*

19. *10-22-45* Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*10/22*.....*1945*..... at *2:15 A*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec.....*1944*..... to.....*Oct. 22*.....*1945*.....
and that I last saw h..... alive on.....*Oct. 21*.....*1945*.....

Immediate cause of death..... DURATION
3 hrs.

Due to.....

Due to.....

Other conditions.....*Arteriosclerosis*
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

23. SIGNATURE.....*R. Murray Fisher*..... M. D. or other
Address.....*18 E. Eager St.*..... Date signed.....*10/22/45*
Baltimore - 2

Dr. A. Murray Fisher
18 E. Elder St

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

09778

Reg. Dist. No. 38

1. PLACE OF DEATH: County..... <u>Baltimore</u> City or town..... <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>md.</u> County..... <u>Baltimore</u> City or town..... <u>Rural</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>Parkton</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....							
3. (a) FULL NAME <u>Benjamin Harrison Bull</u>				3. (b) Social Security Number <u>219-22-3823</u>							
4. Sex <u>Male</u>		5. Color or race <u>white</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>							
6. (b) Name of husband or wife <u>Benjamin H. Bull</u> <u>second</u>				6. (c) If alive, give age years							
7. Birth date of deceased (mo., day, yr.) <u>April 16 1966</u>				8. AGE: Years <u>79</u> Months <u>5</u> Days <u>29</u> It less than one day..... hrs. min.							
9. Birthplace <u>md.</u> <u>Baltimore</u>				10. Usual occupation <u>Black & Secker Mfg Co.</u>							
11. Industry or business <u>Thomas Bull</u>				12. Name <u>Elizabeth Hoshell</u>							
13. Birthplace <u>England</u>				14. Maiden name <u>md.</u>							
15. Birthplace <u>md.</u>				16. Informant <u>James J Bull</u> Address <u>Parkton md.</u> <u>Burial</u> Date thereof <u>10/18/45</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Greenwood Baptist Cemetery</u> Location <u>Ireland md #2</u> <u>H. G. Giffle</u> 18. Funeral director Address <u>Glen Oak, Md.</u>				19. Oct. 16 (Date rec'd by registrar) 19 <u>45</u>			
20. DATE OF DEATH <u>October 15</u> 19 <u>45</u> at <u>4:30</u> P. M.				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19..... and that I last saw..... alive on..... 19..... Immediate cause of death..... <u>Heart disease, coronary -</u> <u>thrombosis & embolus</u> Due to..... <u>arteriosclerosis</u> Due to..... <u>Senile changes</u> Other conditions..... <u>Cerebral hemorrhage (a embolus)</u> (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: <u>None</u> Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....				23. SIGNATURE <u>Rollin B. Hudson M.D. D.M.E.</u> Address..... <u>Towson 4, Md.</u> Date signed <u>10/15/45</u> M. D. or other							

CERTIFICATE OF DEATH

TO BE FILLED BY THE PHYSICIAN

STATE OF MARYLAND

MEDICAL CERTIFICATION

RECEIVED
NOV 5 1945
BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County.....Balto.
 City or town.....Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Hood Nursing Home

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....
 City or town.....Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....2105 Allendale
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

FLORENCE ANN BUNTING

3. (b) Social Security Number

4. Sex.....Female 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Widow
 6.(b) Name of husband or wife.....William H. Bunting
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....Aug. 28, 1859
 8. AGE: Years.....86 Months.....1 Days.....25 If less than one day..... hrs. min.

8. Birthplace.....Maryland
 (Town, county, and state)
Housewife

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name.....Charles G. Downs13. Birthplace.....MarylandMOTHER 14. Maiden name.....Margaret Anderson15. Birthplace.....Virginia16. Informant.....Mr. G. K. HellerAddress.....625 S. Smallwood St.

17. Burial.....10/26/45
 (Burial, cremation, or removal. Which?).....
 (month) (day) (year)

Cemetery or crematory.....Baltimore Cem.Location.....Balto., Md.18. Funeral director.....WM. J. TICKNER & SONSAddress.....Balto., Md.

19. 10/26/45 A. W. Hedrick
 (Date rec'd by registrar).....J.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....October 23, 1945, at.....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 6 1945 to Oct 22 1945
 and that I last saw him alive on Oct-22 1945

Immediate cause of death.....Chor. Myocarditis
 DURATION.....2 wks

Due to.....Coronary Arteriosclerosis
Sclerosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....Chas. Hedrick
 M. D. or otherAddress.....Catonsville Date signed.....10/24

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bd*

CERTIFICATE OF DEATH

09780

Reg. Dist. No. *30*

1. PLACE OF DEATH:

County *Baltimore*
City or town *Oella Md*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *23 yrs*
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *Maryland* County *Baltimore*
City or town *Oella Md*
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Cllovernia Burke

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widow*

6. (b) Name of husband or wife *Thos Henry Burke*

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Aug 6, 1870*

8. AGE: Years *75* Months *2* Days *8* If less than one day hrs. min.

9. Birthplace *Woodlawn, Balto Co. Md*
(Town, county, and state)

10. Usual occupation *Household Duties*

11. Industry or business

12. Name *John Robert*

13. Birthplace *Unknown*

14. Maiden name *Sarah Fishpaw*

15. Birthplace *Unknown*

16. Informant *Addie O. Burke*

Address *Oella, Md.*

17. *Burial* Date thereof *Oct 17, 1945*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Mt. Olive Cemetery*

Location *Randallstown, Md*

18. Funeral director *Easton Sons*

Address *Ellisville City, Md*

19. *10/17 45* *W. C. [Signature]*
(Date rec'd by registrar) Registrar of Deaths

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 14* 19 *45* at *8: A. M*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept 1* 19 *45* to *Oct 14* 19 *45*

and that I last saw him/her alive on *Oct 14* 19 *45*

Immediate cause of death *Atherosclerotic cardio-vascular disease*

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (whore?)

Means of injury Injured at work?

23. SIGNATURE *Gen. A. Kerlan M.D.*
M. D. or other

Date signed *10/16/45*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09781

★ Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
 City or town Lutherville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Broadway Road -

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County _____

City or town Bristolville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Alma Corinthia Burr

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years 78Months 7Days 12

If less than one day

hrs. _____ min.

9. Birthplace

Bristolville, Ohio

(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

General

12. Name

Frances Burr

13. Birthplace

Ohio

14. Maiden name

Sarah Orr

15. Birthplace

Ohio

16. Informant

Guy Wright

Address

Broadway Rd., Lutherville, Pa.

17. Removal

(Burial, cremation, or removal. Which?)

ReinterredDate thereof Oct. 15, 1945

(month) (day) (year)

Cemetery or crematory

Love Funeral Home

Location

Cortland, Ohio

18. Funeral director

John Burns' Sons

Address

Townsend, Md.

19. Date rec'd by registrar

10/15 19 45G. W. Bacon

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1945, at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 18, 1944, to Oct. 15, 1945and that I last saw her alive on Oct. 14, 1945Immediate cause of death Carcinoma, uteruswith metastasis to liver; cachexiaand jaundiceDURATION 2 yrs +

Due to _____

Due to _____

Other conditions Chronic MyocarditisIntestinal Cancer

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Bollin C. Hudson M.D.

M. D. or other _____

Address Townsend, Md.Date signed 10/15/45

RECEIVED BY THE BUREAU OF INVESTIGATION

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED
OCT 18 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (836)

CERTIFICATE OF DEATH

09782

Reg. Dist. No. 35

1. PLACE OF DEATH:

County... BaltimoreCity or town... Parkton Ind. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Ind County... BaltimoreCity or town... Parkton R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Thomas Cairnes

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Margaret Cooper

7. Birth date of deceased (mo., day, yr.)

June 1971

8. (c) If alive, give age

8. AGE: Years Months Days If less than one day

744

..... hrs. min.

9. Birthplace

Harford Co.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

12. Name

Jane Cairnes

13. Birthplace

Harford Co. Ind.

14. Maiden name

Janie Johnson

15. Birthplace

Baltimore Co. Ind.

16. Informant

Mr. Emory Buntin

Address

Parkton, Ind.17. Burial Date thereof Oct. 26-1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Foster's Camp

Location

Parkton R.F.D.

18. Funeral director

Howard S. Markline

Address

White Hall Ind.19. Oct. 24 19 45 Mrs. Howard S. Markline

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 19 45 at 11 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 13 19 45 to Oct. 23 19 45and that I last saw him/her alive on Oct. 23 19 45

Immediate cause of death

Cerebral Thrombosis

DURATION

10 days

Due to

Due to

Other conditions Arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE A. M. FranceAddress Parkton Ind.M. D. SeetherDate signed 10/24/45

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

RIK
OCT 27 1945
BUREAU 1 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09783

CERTIFICATE OF DEATH

★ Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 yrs. 6 mo. 24 days

Hospital, institution, or street address where death occurred:

Spring Grove HospitalHow long in hospital or institution? 43 yrs. 6 mo. 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Prince George County, MarylandCity or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

No

2.(a) If veteran, name war _____

3. (a) FULL NAME

Addie Catilton (Cadington)

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

T. Birth date of

deceased (mo., day, yr.)

Dec. 23, 1861

8. AGE:

Years

Months

Days

If less than one day

83923

.....hrs.min.

9. Birthplace Prince George County, Maryland

(Town, county, and state)

10. Usual occupation House work

11. Industry or business

Home

FATHER

12. Name James West Catilton13. Birthplace Anne Arundel County, Maryland

MOTHER

14. Maiden name Mary Mac Ewing15. Birthplace Prince William County, Virginia16. Informant Hospital records

Address _____

17.

(Burial, cremation, or removal. Which?)

Date thereof

10-18-45
(month) (day) (year)Cemetery or cremator Spring GroveLocation Laurel, Maryland18. Funeral director Laurel, Maryland

Address _____

19.

(Date rec'd by registrar)

19

452411 N. Charles St.

Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1945 at 7:58 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 25, 1937 to Oct. 16 1945and that I last saw him or alive on Oct. 16 1945

Immediate cause of death

Pernicious anemia

DURATION

6 yrs

Due to _____

Due to _____

Other conditions HemiplegiaSince
1/5/45

(Include pregnancy within 3 months of death)

Major findings of operations

No

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

M. D. or other

Address CatonsvilleDate signed 10/16/45

RECEIVED
OCT 22 1945
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-27)

CERTIFICATE OF DEATH

★ 0978430
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 10 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 2 years, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Shadyside
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION) ✓
2.(a) If veteran, name war _____

3. (a) FULL NAME

Ella May Conrad

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Conrad Harvey

7. Birth date of deceased (mo., day, yr.)

August 11, 18846. (c) If alive, give age 65 years

8. AGE:

Years

61

Months

1

Days

27

If less than one day

_____hrs. _____min.

9. Birthplace

West Virginia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

John Barrett

13. Birthplace

United States

MOTHER

14. Maiden name

Rebecca Green

15. Birthplace

Virginia

18. Informant

Hospital records

Address

Catonsville-28, Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof

10-11-45
(month) (day) (year)

Cemetery or crematory

Fort Lincoln Cem.

Location

W. Washington D.C.

18. Funeral director

George R. Farley

Address

Catonsville Md.

19.

(Date rec'd by registrar)

10/11/45
W.C. Lindsey
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 19 45 at 10:35p M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28 19 43 to October 8 19 45and that I last saw her alive on October 8 19 45

Immediate cause of death

Cerebral hemorrhage

DURATION

3 days

Due to

Hypertensive cardio-renal-vascular diseaseIndefinite

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work? _____

23. SIGNATURE

Robert E. Gardner, M.D. M. D. or otherCatonsville-28, Md.Date signed 10/8/45

RECEIVED

OCT 22 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

09785

P

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH

County 227 Clarendon Ave.City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 years

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County PikesvilleCity or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)Street No. 227 Clarendon Ave.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Samuel Marvin Cooper

3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mary M. Cooper6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) December 11/18878. AGE: Years 57 Months 10 Days 10 If less than one day hrs. min.9. Birthplace Pearisburg Va.
(Town, county, and state)10. Usual occupation Storekeeper/Singer11. Industry or business U. S. Gov't12. Name John Cooper13. Birthplace England14. Maiden name Eliza Connelly15. Birthplace Virginia16. Informant Mary M. CooperAddress 227 Clarendon Ave17. Burial Date thereof Oct 13/1945
(Burial, cremation, or removal, where?) (month) (day) (year)Cemetery or crematory StaffordvilleLocation Staffordville Va.18. Funeral director Harry H. ArmasosAddress 4204 Ridgewood Ave19. 10/11 19. 45 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 19. 45 at 14.5 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. 1939 to Death 19. 1945
and that I last saw him alive on Oct 11, 1945 19. 1945Immediate cause of death Cerebral embolusDURATION 1 hourDue to Coronary thrombosis 2 months

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ala Bernster M. D. or other
Address 1039 N Calvert St Date signed Oct 11, 1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10597 Cabot

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1912)

CERTIFICATE OF DEATH

09786

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Baltimore
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, institution, or street address where death occurred:
208 Chatsworth Ave
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 208 Chatsworth Ave
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME

Sarah Virginia Corroum3. (b) Social Security Number
None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife William Jackson Corroum
6. (c) If alive, give age - years
7. Birth date of deceased (mo., day, yr.) January 30 1862
8. AGE: Years 83 Months 8 Days 25 If less than one day - hrs. - min.

9. Birthplace Jarrettsville-Harford Co-Md
(Town, county, and state)
10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Thomas S. Denbow
13. Birthplace Balto Md
14. Maiden name Catherine Stridehoff
15. Birthplace Penna

16. Informant William Thomas Corroum
Address Reisterstown Md

17. Burial Date thereof Oct 26 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Old Brick Baptist Cemetery
Location Jarrettsville Md
18. Funeral director Wm Berryman & Sons
Address Reisterstown Md

19. Oct 25 1945 Mary B. Rhine
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23-45 3:10 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1-38 to 10-23-45
and that I last saw him alive on 10-23-45

Immediate cause of death

myocarditis (decompensating)
Due to atherosclerosis

Due to

Other conditions

nephritis - chronic
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. -

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE J. B. Saffell M.D. or other

Address Reisterstown Md Date signed 10-25-45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

NAME OF CHILDREN

DATE OF BIRTH OF CHILDREN

NAME OF CHILDREN

DATE OF BIRTH OF CHILDREN

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DATE OF BIRTH OF CHILDREN

NAME OF CHILDREN

RECEIVED

OCT 27 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

CERTIFICATE OF DEATH

09787

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore
City or town Broadale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto
City or town Broadale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 48 Broadship Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George W. Higgins

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male W widow

6.(b) Name of husband or wife Margaret J. (Cleveland)

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) July 3 1866

8. AGE: Years Months Days If less than one day
74 hrs. min.

9. Birthplace Brooktop City Pa
(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business

12. Name Samuel Higgins

13. Birthplace Pa

14. Maiden name Frances Montgomery

15. Birthplace Pa

16. Informant Miss Ethel McShane

Address 48 Broadship Rd.

17. Burial Date thereof 10-10-45
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Old Fellows Cem.

Location Crownville, Pa.

18. Funeral director J. J. Puck

Address 5305 Harbor Rd.

19. 10/10/45 19 W. McShane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 19 45 at 330 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 19 45 to Oct 6 19 45

and that I last saw him alive on 10

Immediate cause of death

Carcinoma of Stomach
Due to Cervical Metastasis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE M. B. Davis, M.D.

Address Dundalk, Md. M. D. or other 10/6/45

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100
121945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, MarylandHow long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2212 W. Booth St.
(If rural, give LOCATION)2.(a) If veteran, name war WW II ✓

3.(a) FULL NAME

STEPHEN DILLINGER

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 12/25-1913-

8.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

31 10 7 hrs. min.9. Birthplace Austro Hungarian
(Town, county, and state)10. Usual occupation Molder11. Industry or business FoundryFATHER 12. Name John Dillinger13. Birthplace Austro HungarianMOTHER 14. Maiden name Caroline Stoffle15. Birthplace Austro-Hungary16. Informant Clinical Records, Vets. Adm. Fac.Address Ft. Howard, Maryland17. BURIAL Date thereof 10/22/45
(Burial, cremation, or removal? Which?) (month) (day) (year)Cemetery or crematory EvergreenLocation Baltimore, Md.18. Funeral director F. B. Whipple, Inc.Address 1850 N. Baltimore St.19. Oct 22 19 45 OFF

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 19 45, at 1:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 17, 19 45, to October 18, 19 45and that I last saw him alive on October 18, 19 45

Immediate cause of death

Pneumococcic Meningitis

DURATION

36 Hrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE AmBalterA. M. BALTER, LT. COL., M.C.P. CHIEF DIR.Address Fort Howard, Md. Date signed 10-18-45

RECEIVED

OCT 20 1945

BUREAU

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

09789

1. PLACE OF DEATH

County Baltimore Registration Dist. No. _____
 Village or City Catonsville No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

Eileen Cecelia Doyle
 (a) Residence: No. Baughers of the Eucharist Ward. _____
 (Usual place of abode) _____
 If nonresident give city or town and State _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____		
6. DATE OF BIRTH (month, day, and year) <u>June - 1872</u>		
7. AGE Years <u>73</u>	Months <u>4</u>	Days _____ If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Bookkeeper</u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. _____	
	10. Data deceased last worked at this occupation (month and year) _____	11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) Baltimore
 (State or country) _____

MOTHER FATHER	13. NAME <u>Michael H. Doyle</u>
	14. BIRTHPLACE (city or town) <u>B. Va.</u> (State or country) _____
	15. MAIDEN NAME <u>Eileen D. Miller</u>
	16. BIRTHPLACE (city or town) <u>N.Y.</u> (State or country) _____

17. INFORMANT Mrs. J. E. Kenney
 (Address) 600 Northampton

18. BURIAL, CREMATION, OR REMOVAL
 Place Cathedral Date 10/3, 1945

19. UNDERTAKER J. J. Faherty, Son
 (Address) 218 Light St.

20. FILED 10-2, 1945 Act. Reg.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

October 1st, 1945
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from

July, 1945, to Oct 1, 1945

I last saw him alive on Sept 27, 1945; death is said to have occurred on the date stated above, at _____ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cardio Vascular
Renal Disease
 Date of onset Sept 1st

Other Contributory Causes of Importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? No Date of Injury _____, 1945

Where did injury occur? _____

(Specify city or town, county and State)
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) Alfred H. Hammer M. D.

(Address) Catonsville - 28th Ind.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Bacon
Taylor Avenue

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
City or town Baltimore Co. - Towson Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
Crummell Bridge Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto.
City or town Baltimore Towson-Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Crummell Bridge Road
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Martin J. Dunn

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife Christina Dunn
7. Birth date of deceased (mo., day, yr.) 1866
8. AGE: Years 29 Months ? Days ? If less than one day _____ hrs. _____ min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden name ?
15. Birthplace ?

16. Informant Mrs. James Dione De Ono
Address 8304 Harford Road -14-

17. Burial Date thereof 10-29-45
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Baltimore

Location Baltimore

18. Funeral director Leonard J. Ruck

Address 5305 Harford Road -14-

19. 10/28 19 45 A.M. Bacon
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26th, 19 45, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 34 to Oct. 26 19 45
and that I last saw him alive on Oct. 25 19 45

Immediate cause of death Chr. myocarditis

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE A. M. Bacon M.D.

M. D. or other

Address 2810 Jay lor Ave. Date signed 10/28/45

301 127
09790

RECEIVED
OCT 30 1965
U.S. AIR FORCE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
 County... Baltimore
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 1 day
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 2 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County...
 City or town... Baltimore-30
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 18 West Hamburg Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Ogle Eaton

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife... Minnie Christerfer
 6. (c) If alive, give age 78 years
 7. Birth date of deceased (mo., day, yr.) January 15, 1864
 8. AGE: Years 81 Months 8 Days 17 If less than one day
 ... hrs. ... min.

9. Birthplace... Queen Anne's County, Md.
 (Town, county, and state)
 10. Usual occupation... Laborer
 11. Industry or business... Unknown
 12. Name... Jacob Eaton
 13. Birthplace... ?
 14. Maiden name... ?
 15. Birthplace... ?
 16. Informant... Hospital records
 Address... Catonsville-28, Md.

17. Burial Date thereof... 10/5/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Kingsley Chapel Cemetery
 Location... Queen Anne Co. Md.
 18. Funeral director... John F. Henry Inc
 Address... 115 Light St.
 19. 10/4 45 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... October 2 19 45, at 3:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 31 19 45, to October 2 19 45
 and that I last saw him alive on October 2 19 45

Immediate cause of death...
Acute pulmonary oedema

DURATION
2 hrs.

Due to... Chronic hypertensive cardio-renal-vascular disease

Indef.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations...

Autopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert E. Gardner, M.D. M. D. or otherAddress... Catonsville-28, Md. Date signed... 10/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. 09792 38

1. PLACE OF DEATH
 County Baltimore County
 City or town Lutherville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 31 yrs
 Hospital, institution, or street address where death occurred
3 Burton Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Lutherville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3 Burton Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Matilda Edwards

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife William Orville Edwards 6.(c) If alive, give age 79 years
 7. Birth date of deceased (mo., day, yr.) July 30 1863
 8. AGE: Years 82 Months 2 Days 20 If less than one day
hrs. - min.

9. Birthplace Stevenson Md
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business None

MOTHER FATHER
 12. Name William Eckers
 13. Birthplace Hartford City
 14. Maiden name Rachael Pocock
 15. Birthplace Maryland
 16. Informant Mr William R.C. Edwards
 Address 3 Burton Ave
 17. Burial Date thereof Oct 19 1945
 (Burial, cremation, or removal, which) (month) (day) (year)
 Cemetery or crematory Lutherville
 Location Baltimore Co. Md
 18. Funeral director John S. Brown & Sons
 Address Lowers Rd
 19. Oct 19 1945 (Date rec'd by registrar) Registrar John S. Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1945 at 4:25 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 1945 to October 19 1945
 and that I last saw her alive on October 15 1945
 Immediate cause of death Cardiac Failure
 DURATION 14 months
 Due to Chronic Cardiac Failure
 Due to Age
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Charles H. Howell M.D.
 Address 7301 York Rd M. D. or other
Baltimore 4 Date signed 10/19/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

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PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RECEIVED

NOV 5 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09793

Reg. Dist. No. 4x

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 52 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Facility, Ft. Howard, Maryland
 How long in hospital or institution? 52 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 610 Jasper Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I ✓

3. (a) FULL NAME

JAMES H. EMORY

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Minnie Emory7. Birth date of deceased (mo., day, yr.) 4-9-97

8. AGE: Years Months Days If less than one day

48

6

13

hrs. min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Porter

11. Industry or business

12. Name Joseph13. Birthplace Maryland14. Maiden name Eliza Johnson15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. Fac.
Address Fort Howard, Maryland17. Burial Date thereof Oct 26, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory National CemeteryLocation Baltimore, Maryland18. Funeral director Mrs. Katherine WilliamsAddress 322 N. Schenck St.19. 10/26/45 A. W. Hadriel
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1945 at 3:22A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 31, 1945 to October 22, 1945
 and that I last saw him alive on October 22, 1945

Immediate cause of death
Tuberculosis, pulmonary, chr. far
advanced active III
 DURATION 6 Mos. plus

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

RMB W. F. Richards23. SIGNATURE H. Y. RICHARDS, MAJOR, M.C. ACT. CLIN.Address Ft. Howard, Md. DIR. 10-22-45
Date signed _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B-6*

CERTIFICATE OF DEATH

09794

Reg. Dist. No. 9

1. PLACE OF DEATH:
County Baltimore
City or town Towson Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Oct 21, 1944
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since Oct 21, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No. Star Route
(If rural, give LOCATION)
2. (a) If veteran, name war ✓

3. (a) FULL NAME
Argentine Maurice Estenez

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife George Estenez

7. Birth date of deceased (mo., day, yr.) June 12, 1920 8. (c) If alive, give age 23 years

8. AGE: Years 23 Months 3 Days 24 If less than one day
.....hrs.min.

9. Birthplace Michigan
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Kayira Maure

13. Birthplace Spain

14. Maiden name Augusta Sato

15. Birthplace Spain

16. Informant Personal History Hospital Records

Address Eudowood Sanatorium, Towson 4, Md.

17. Removal Date thereof Oct. 5-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Waldorf Md

Location Smith & Ryon

18. Funeral director Waldorf Md

19. 10-5 19 45 Overseas
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1945 at 2:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21 1944 to Oct 4 1945 and that I last saw her alive on October 4 1945

Immediate cause of death..... DURATION

Pulmonary Tuberculosis Since
Due to.....

Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE William A Bridge M. D. or other
Address Towson 4 Maryland Date signed 10-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 44

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address *Middle River Bottling Co.*
 (c) Hospital or institution: *Balts. Co.*
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Ind* (b) County *Baltimore*
 (c) City or town *Miller River*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *Claver Road* (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

*Christian**Foltz*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 30 - 1885

8. AGE:

Years

Months

Days

If less than one day

*60**8**9*

hr.

min.

9. Birthplace

Balts. Co.

(Town, county, and state)

10. Usual Occupation

Labrer

11. Industry or business

Middle River Bottling Co.

FATHER

12. Name

Christian Foltz

13. Birthplace

Germany

MOTHER

14. Maiden Name

Mary Bauer

15. Birthplace

Germany

16 (a) Informant

Joseph Foltz

(b) Address

Middle River

17 (a)

Burial

(b) Date thereof

Oct. 11 - 45

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Zion Lutheran

Location

Stonemans Run

18 (a) Funeral director

John S. Connolly

(b) Address

Baltimore Ave. East

Dec. 10 - 45

John S. Connolly

REGISTER

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 8, 1945, at 7 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury *Oct. 8, 1945* *4 A.M.*

(b) Where did injury occur? *Middle River Bottling Co.*

(c) Did injury occur at home, on farm, industrial place, in public place? *Industrial* While at work? *Yes*

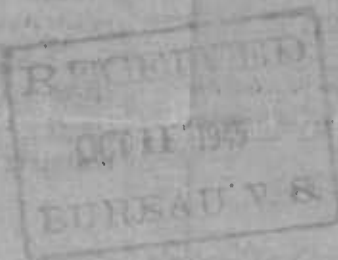
(d) Means of injury *Blunt Force*

23. Signature *Robert C. Graham* M.D.

Medical Examiner.

Date signed

Oct. 8, 1945



COPY SENT TO

Co. Health Officer

10/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09796

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Longgreen
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
 City or town Longgreen
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

THOMAS H. FOSTER

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Florence H. Foster

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 9, 1890

8. AGE: Years 55 Months 1 Days If less than one day hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name ? Davidage

13. Birthplace Md.

MOTHER 14. Maiden name Georgie Foster

15. Birthplace Md.

16. Informant Mrs. Florence H. Foster

Address Longgreen, Md.

17. Burial Date thereof 10-18-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion Cem.

Location Longgreen, Md.

18. Funeral director Mrs. Frances A. Hemsley

Address 578 W. Biddle St.

19. Oct 16 19 45 awd hudson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 19 45, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10, 19 45, to October 14, 19 45

and that I last saw him alive on Oct. 14, 19 45

Immediate cause of death Repeated Convulsive Seizures

Due to Malignant Hypertensive Cardiac Vascular Disease

Other conditions

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DURATION

20 hrs

1 yr

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09797

★ Reg. Dist. No. 44

1. PLACE OF DEATH: County..... <u>Baltimore</u> City or town..... <u>Gray Manor</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>md.</u> County..... <u>Balts.</u> City or town..... <u>Gray Manor</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>2807 Paige Ave</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Chester Clemment Fowble</u>				3. (b) Social Security Number			
4. Sex <u>m.</u>		5. Color or race <u>W.</u>		6. (a) Single, married, widowed, or divorced <u>Single</u>			
6. (b) Name of husband or wife							
7. Birth date of deceased (mo., day, yr.) <u>Nov. 14 - 1944</u>							
8. AGE: Years Months Days If less than one day <u>11</u> <u>6</u> hrs. min.							
9. Birthplace <u>Baltimore</u> (Town, county, and state)							
10. Usual occupation							
11. Industry or business							
FATHER		12. Name <u>James Hugh Fowble</u>					
MOTHER		13. Birthplace <u>Balts.</u>					
14. Maiden name <u>Jennie Hoffmeister</u>		15. Birthplace <u>Balts.</u>					
16. Informant <u>Parents</u>							
Address <u>2807 Paige Ave</u>							
17. (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof..... <u>Oct. 22-45</u> (month) (day) (year) Cemetery or crematory..... <u>Sacred Heart</u> Location..... <u>Union Hill Rd.</u>							
18. Funeral director <u>John G. Connelly</u> Address <u>Evans, md.</u>							
19. <u>Oct. 22 45</u> <u>John G. Connelly</u> (Date rec'd by registrar) Registrar							
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>Oct. 20 -</u> 19 <u>45</u> , at <u>6 P.M.</u>							
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from <u>Aug. 15</u> to <u>Oct. 19</u> and that I last saw him alive on <u>19th</u> 19 <u>45</u>							
Immediate cause of death <u>m. atherosclerosis</u>							
DURATION <u>2 min.</u>							
Due to							
Due to							
Other conditions							
(Include pregnancy within 8 months of death)							
Major findings of operations							
Date of op.							
Autopsy results							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following:							
Accident, suicide, or homicide..... Date of.....							
Where did injury occur?..... (City or town) (County) (State)							
Injured at home, farm, industry, public place (where?).....							
Means of injury..... Injured at work?.....							
23. SIGNATURE <u>Harry Grebert</u> M. D. or other							
Address..... <u>109 Trappe Rd</u> Date signed..... <u>10/22/45</u>							

RECEIVED
OCT 23 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17020

CERTIFICATE OF DEATH

09798

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... Baltimore Co.City or town... Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 mo.

Hospital, institution, or street address where death occurred:

Edmondson Ave 244 Stagners Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County...City or town... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2038 Harbor Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frank B. Fuller

4. Sex

M.

5. Color or race

W

6.(a) Single, married, widowed, or divorced

✓

3. (b) Social Security Number

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6/3/1880

8.(c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

65

hrs. min.

9. Birthplace

Va.
(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

Contractor

12. Name

James B. Fuller

13. Birthplace

Va.

14. Maiden name

Elizabeth McCorn

15. Birthplace

Va.

16. Informant

A. H. Friend

Address

4404 Bedford Place

17. Burial, cremation, or removed. Which?

Burial Date thereof 10/9/45
(month) (day) (year)

Cemetery or crematory

London Park

Location

Route 214

18. Funeral director

Edmund O. McFarland

Address

Catonsville Md

19. (Date rec'd by registrar)

10/9/45 J. C. Anderson
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 45 at 2:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death

Fractured skull
fractured pelvis

Due to

fractured legs

Due to

accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Oct 7 45Where did injury occur? Catonsville Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) public highwayMeans of injury Struck by auto Injured at work?

23. SIGNATURE

J. C. Anderson M. D. or otherAddress 1000 Red Oak Date signed Oct 9 45

WARRANT AND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

STATE OF DEATH

MEDICAL CERTIFICATE

RECEIVED
NOV 7 1968
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... **Baltimore**
 City or town..... **Fort Howard**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **344 Days**
 Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
 How long in hospital or institution?..... **344 Days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County.....
 City or town..... **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... **WW-I**

3. (a) FULL NAME

JOHN W. GALLOWAY

3. (b) Social Security Number

4. Sex..... **Male** 5. Color or race..... **Colored** 6. (a) Single, married, widowed, or divorced..... **Separated**
 6. (b) Name of husband or wife..... **Bessie Galloway**
 6. (c) If alive, give age..... **1** years
 7. Birth date of deceased (mo., day, yr.)..... **January 1881**
 8. AGE: Years..... **64** Months..... **8** Days..... If less than one day..... hrs. min.

9. Birthplace..... **Baltimore, Maryland**
 (Town, county, and state)
 10. Usual occupation..... **Unemployed**
 11. Industry or business.....
 12. Name..... **Samuel Galloway**
 13. Birthplace..... **North Carolina**
 14. Maiden name..... **Nancy ?**
 15. Birthplace..... **Maryland**

16. Informant..... **Clinical Records, Vets. Adm. Fac.**
 Address..... **Fort Howard, Maryland**

17. Burial..... **Burial** Date thereof..... **10 10 45**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Baltimore National**
 Location..... **Baltimore, Md.**

18. Funeral director..... **Charles A. Law**
 Address..... **802 1/2 Madison Ave.**

19. **10-8 45** Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **October 6, 1945** at **8:50 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 27, 1944 to **October 6, 1945**
 and that I last saw him alive on **October 6, 1945**

Immediate cause of death.....
Heart disease, Coronary Arterio-
sclerosis, cardiac enlargement,
xxx myocardial insufficiency

DURATION

1 Yr.
plus

Due to.....
 Other conditions..... **Pulmonary, edema, acute** **Sudden**
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... **Ann B. Balter**
A.M. BALTER, LT. COL., M.C. CLIN. DIR.
 Address..... **Fort Howard, Md.** Date signed..... **10-8-45**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 200 days, 9 1/2 hours

Hospital, institution, or street address where death occurred:

Veterans Hospital, Ft. Howard, MarylandHow long in hospital or institution? 200 days, 9 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Lewistown District
(If outside city or town limits, write RURAL and give nearest town)Street No. Route # 3
(If rural, give LOCATION)2.(a) If veteran, name war Spanish American War

3.(a) FULL NAME

LEWIS HANSON GAUGH

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single6.(b) Name of husband or wife Single

7. Birth date of

deceased (mo., day, yr.)

November 6, 1874

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

711027

.....hrs.min.

9. Birthplace Frederick Co., Maryland

(Town, county, and state)

10. Usual occupation Unemployed11. Industry or business -

MOTHER FATHER

12. Name William Gaugh13. Birthplace Maryland14. Maiden name Catherine Hemmrick15. Birthplace Maryland16. Informant Hospital Records, Veterans AdministrationAddress Fort Howard, Md.

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof Oct 31-45
(month) (day) (year)Cemetery or crematory Lewistown CemLocation Lewistown Md18. Funeral director M. J. CreagerAddress Churmont Md

19.

10-29-45
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1945, at 9:30 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1945, to October 28 1945, and that I last saw him alive on October 28 1945.

Immediate cause of death

PNEUMONIA, LOBAR

DURATION

Two days

Due to

Due to

Other conditions

HEMIPLEGIA, LEFTARTERIOSCLEROSIS, GENERAL

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

William B. Harsh M.D.

M. D. or other

Address Fort Howard, Md Date signed 10/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information-carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

09801

1. PLACE OF DEATH:
 County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 months, 10 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?..... 3 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County.....
 City or town..... Baltimore-31
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 26 S. Madeira Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... ☒

3. (a) FULL NAME Rose Gernhardt 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife..... George Gernhardt
 7. Birth date of deceased (mo., day, yr.) November 28, 1881 (1879)
 8. AGE: Years (65) 63 Months 10 Days 26 If less than one day
 hrs. min.

9. Birthplace..... Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business Home
 12. Name..... ? Mencke
 13. Birthplace..... ?
 14. Maiden name..... ?
 15. Birthplace..... ?

16. Informant..... Hospital records
 Address..... Catonsville-28, Maryland

17. Burial Date thereof..... Oct. 26/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Holy Redeemer
 Location..... Belair Road

18. Funeral director..... Lilly & Zeiler Inc.
 Address..... 443 S. Wolfe St.

19. 10/24 19 45 J. B. G. E. Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 23 19 45 at 4:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 13 19 45 to October 23 19 45
 and that I last saw h..... er..... alive on..... October 23 19 45

Immediate cause of death..... Terminal pneumonia DURATION 24 hours

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 9 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Robert E. Gardner M.D. M. D. or other

Catonsville-28, Md. Date signed 10/23/45

RECORDED

NOV 1 1945

BUREAU V.S.

RECEIVED

OCT 25 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (232)

CERTIFICATE OF DEATH

09803

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Balto.
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
Dulaney Valley Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Balto.
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Locust Vale - Dulaney Valley Rd.
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

ELMA HALSTEAD GOULD

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Frank Gould

7. Birth date of deceased (mo., day, yr.) July 25, 1873
6.(c) If alive, give age _____ years

8. AGE: Years 72 Months 3 Days 0 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

FATHER 12. Name Edwin G. Halstead
13. Birthplace England

MOTHER 14. Maiden name Amelia Cline
15. Birthplace Baltimore

16. Informant Mr. Frank Gould
Address Dulaney Valley Rd., Towson

17. Burial Date thereof 10/27/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. Oct 27 19 45 Adm Halstead
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 19 45 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to Oct 25 19 45 and that I last saw him alive on Oct 24 19 45

Immediate cause of death Cerebral hemorrhage DURATION 10 hours

Due to arteriosclerotic general cerebral 10 yrs

Due to Hypertension 10 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A.S. Charfant M. D. or other _____

Address 6210 York Date signed Oct 27

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

Reg. Dist. No. 09804 30

1. PLACE OF DEATH:

County Baltimore
City or town 105 Oak Drive Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 10 mos.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 105 Oak Drive
(If rural, give LOCATION)
2. (a) If veteran, name war None

3. (a) FULL NAME

Emma Rossberg Grimes

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Henry Thomas Grimes 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Mar. 27, 1879

8. AGE: Years 66 Months 6 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Charles Rossberg

13. Birthplace Oschatz, Germany

14. Maiden name Friedericka Eitner

15. Birthplace Schwabenbach Germany

16. Informant Herman Rossberg

Address 7 S. Wickham Rd. Balto-29, Md.

17. Burial Date thereof Oct. 13, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Johns Cemetery

Location Ellicott City, Howard Co. Md.

18. Funeral director Easton Sons

Address 608 Frederick Ave. Catonsville, Md.

19. 10/13/45 H. C. Anderson
(Date rec'd by registrar) (Signature) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1945 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-5 19 45 to 10-10 19 45

and that I last saw him/her alive on 10-10 19 45

Immediate cause of death Coronary Embolism

Due to Cardio Vascular Renal Disease

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE W. C. Anderson M.D.

Address 802 2nd Ave. Catonsville, Md. Date signed 10-10-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 7 1945

BUREAU

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No.

09805

1. PLACE OF DEATH:

County BaltimoreCity or town Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5519 Selma Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5519 Selma Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

EMIL PAUL GUNTHER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Widower</u>

6.(b) Name of husband or wife Katie Gunther

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1875

8. AGE:	Years	Months	Days	If less than one day
<u>69</u>	<u>10</u>	<u>2</u>	<u>.....</u>	<u>.....</u>
			hrs.	min.

9. Birthplace Germany

(Town, county, and state)

10. Usual occupation Treasurer11. Industry or business Sheet Metal Business12. Name William Gunther13. Birthplace Germany14. Maiden name Pauline Schneider15. Birthplace Germany16. Informant Mr. John H. GuntherAddress 1415 Sulphur Spring Road17. Burial Date thereof 10/4/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lorraine Cem.Location Woodlawn, Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 10/4 45 Ampeknich

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 19 45 at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 30 19 45 to Oct. 1 19 45and that I last saw him alive on Oct. 1 19 45

Immediate cause of death

Gastric Intestines - 5
diagnosis and vomiting

Due to

Due to

Other conditions Probable Coronary EmbolismC. acute pulmonary congestion
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Tram Injured at work?23. SIGNATURE Tram M. D. or otherAddress Medicine at Reg Date signed Oct 3-45

DURATION

24 hrs1 hr

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and intelligibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 901

CERTIFICATE OF DEATH

09806

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 months, 3 daysHospital, institution, or street address where death occurred:
Spring Grove State HospitalHow long in hospital or institution? 2 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 615 N. Highland Avenue, Balto. 5
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

Richard Habicht

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Irene Jones

7. Birth date of

deceased (mo., day, yr.) March 28 18936.(c) If alive, give age 47 years

8. AGE:

Years

Months

Days

If less than one day

5268

.....hrs.

.....min.

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

Machinist

11. Industry or business

FATHER
MOTHER

12. Name

Randolph Habicht

13. Birthplace

Germany

14. Maiden name

Laura Metz

15. Birthplace

Germany

16. Informant

Spring Grove State Hospital Records

Address

Catonsville, Maryland

17.

Burial

Date thereof

Oct-8-45
(month) (day) (year)

Cemetery or crematory

Oak Lawn Cem

Location

Eastern Ave

18. Funeral director

Phyllis Miller Inc

Address

2435 E. Oliver St

19.

10-619 45R. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 19 45, at 5:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 2, 1945 to October 5, 1945and that I last saw him alive on October 5, 1945

Immediate cause of death

General Paralysis of the Insane

DURATION

BeforeAugust 2, 1945

Due to

Due to

Other conditions

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert E. Gardner

M. D. or other

Address Spring Grove State Hospital Date signed Oct. 5, 1945

Rec'd 10/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09807

38

1. PLACE OF DEATH:

County Balt.
City or town Hillside Rd. Stevenson, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? just arrived - at work
Hospital, institution, or street address where death occurred:
River estate at Stevenson, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4203 Springwood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Lawrence H. Hahn

3. (b) Social Security Number

212-07-1319

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White married

6.(b) Name of husband or wife Amelia M. Hahn

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 25, 1881

8. AGE: Years Months Days If less than one day
64 2 7 hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Inten. Designer

11. Industry or business C. J. Benson Co.

12. Name Henry Hahn

13. Birthplace Maryland

14. Maiden name Mary Braun

15. Birthplace Maryland

16. Informant Mrs. Amelia M. Hahn

Address 4203 Springwood Ave

17. Burial Date thereof 10/6/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Moreland Park

Location Taylor Ave

18. Funeral director Howard W. Bluff Jr.

Address 4914 Belair Road

19. 10/5/45 A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1945 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 1945 to Oct 3 1945 and that I last saw him not seen alive alive on Oct 3 1945

Immediate cause of death Angina Pectoris DURATION 30 min

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. D. Caples, M.D. M. D. or other

Address Reisterstown, Md. Date signed 10-4-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-8

CERTIFICATE OF DEATH

09808



Reg. Diat. No. 40

1. PLACE OF DEATH:

County BaltoCity or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

Vappa Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto. Co.City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)Street No. Vappa Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary M. Hartlove

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife James H. Hartlove7. Birth date of deceased (mo., day, yr.) Aug. 15th 1853

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

92 1 22 hrs. min.9. Birthplace Harford Co. Md

(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Thomas Shanklin13. Birthplace Harford Co. Md14. Maiden name Rachael Tucker15. Birthplace Harford Co. Md16. Informant Mrs. H. ZanderAddress #110 Fullerton P.O.17. Burial Date thereof 10 10 45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cem.Location Anne Arundel Co. Md18. Funeral director London Funeral HomeAddress 7401 Belair Rd.19. 10/9/45 19 10/9/45

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7th 1945 at 3²⁵ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 4, 1945 to Oct. 7, 1945and that I last saw him alive on Oct. 6, 1945

Immediate cause of death

ArterioscleroticCardio-vascularDue to Chronic

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Yd. G. Groat, M.D.Address 8100 Harford Rd. Date signed 10/8/45

RECEIVED

OCT 23 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 09809 38

1. PLACE OF DEATH:

County BaltoCity or town 506 Park Ave
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town 506 Park Ave
(If outside city or town limits, write RURAL and give nearest town)Street No. Towson, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William A. Hauspiper

3. (b) Social Security Number

215-09-3661

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Genevieve

7. Birth date of

deceased (mo., day, yr.)

April 28, 18826. (c) If alive, give age 65 years

8. AGE:

Years

Months

Days

If less than one day

63

hrs. min.

9. Birthplace

Balto Co
(Town, county, and state)

10. Usual occupation

Balto Transit Co.

11. Industry or business

FATHER

12. Name

13. Birthplace

Balto Co.

14. Maiden name

Emma

15. Birthplace

Balto Co.

16. Informant

Address

Genevieve Hauspiper
506 Park Ave
Burial

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Holy Redeemer

Location

4300 Belair Rd.

18. Funeral director

Address

M. W. K. Dipoli's Sons
Lombard & Ann Sts.

19.

(Dated and by registrar)

19

45At Redfield

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 81945 at 4:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 201945to Oct 61945

and that I last saw him alive on

Oct 61945

Immediate cause of death

DURATION

Coronary Occlusion1 yr.

Due to

Arterio-sclerosis

Due to

Hypertensionrule

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

10/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County... 2708 Glendale Road

City or town... Parkville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

at above address

33 yrs

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Balto.

City or town... Parkville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2708 Glendale Road

(If rural, give LOCATION)

2(a) If veteran, name war... no

3. (a) FULL NAME

CHRISTIAN HAX

3. (b) Social Security Number

212-16- 5439

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.) Feb. 19, 1871

8. AGE:

Years

Months

Days

It less than one day

74

74

7

15

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Furniture Merchant

11. Industry or business

Louis Hax & Sons, Inc.

12. Name

Louis Hax

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden name

Josephine Michael

15. Birthplace

Baltimore, Maryland

16. Informant

Mrs. Mary C. Maier

Address

1905 Barclay Street

17.

Burial

Date thereof

10-3-45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Loudon Park Cemetery

Location

Baltimore, Maryland

18. Funeral director

HENRY SANDER & SONS, INC.

Address

NORTH AVE. & BROADWAY

19.

Oct 5, 1945

(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH... Oct. 2, 1945, at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1944 to Oct. 2, 1945

and that I last saw him alive on Oct. 2, 1945

Immediate cause of death

DURATION

Carcinoma of prostate

1 yr

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harold A. Gott, M.D.

M. D. or other

Address... 8100 Harford Rd. Date signed 10/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County BaltimoreCity or town Towson, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution?

3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State IndCounty Balto.City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3114 S. Elm St

(If rural, give LOCATION)

2. (a) If veteran, name war NO

3. (a) FULL NAME

Emma Margaret Hemigan

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Elmer Hennigan Sr

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

May 28, 1913

8. AGE:

Years

Months

Days

If less than one day

32428

hrs.

min.

9. Birthplace

Balto Co. Ind

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Herman Spielman

13. Birthplace

Balto Ind

MOTHER

14. Maiden name

Annie Stump

15. Birthplace

Balto Ind

16. Informant

Address

Personal History Hospital RecordsEudowood Sanatorium, Towson 4, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 30/45

(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

Eastern ave. E. pt.

18. Funeral director

Address

Gilly & Zeiler Inc.403 S. Wolfe St.

19.

(Date rec'd by registrar)

20/10/45

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 2619 45 at 1259 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 2319 45 toOct 26 19 45

and that I last saw him alive on

Oct 2519 45

Immediate cause of death

Pulmonary TB

DURATION

4 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William A. Bridges

M. D. or other

Address

Towson, Maryland

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of MARYLAND STATE DEPARTMENT OF HEALTH
date of birth is shown on

2411 N. Charles St., Baltimore 721

NOV 6 1945

CERTIFICATE OF DEATH

09812

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BALTO.
City or town ESSEX MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
1313 EASTERN AVE.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 60 YEARS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTO.
City or town ESSEX MD. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1313 EASTERN AVE.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR NO

3. (a) FULL NAME

JOHN F. HOCK

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE W WHITE WIDOWER

6 (b) Name of husband or wife ANTIONETTE HOCK

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) FEB. 26 1866 1865

8. AGE: Years Months Days If less than one day
80 7 16 hrs. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business SCAFFOLD BUILDER FOR SELF

12. Name GEORGE HOCK

13. Birthplace GERMANY

14. Maiden name SUSANNA ?

15. Birthplace GERMANY

16. Informant FRANK HOCK (SON)

Address 1313 EASTERN AVE.

17. BURIAL Date thereof OCT. 17/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

16. Funeral director Lilly and Zeiler Inc.

Address 403 S. WOLFE ST.

19. 10/15 19 45 John J. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

AM.

20. DATE OF DEATH OCT. 14 19 45, at 12/20

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 19 45, to Oct 14 19 45
and that I last saw him alive on Oct 14 19 45.

Immediate cause of death

Cerebral Thrombosis

DURATION

Instantaneous

Due to arterio-sclerotic-cerebro-vascular disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE

W. W. W. Gardner
Balto 6

M. D. or other

Date signed 10/15/45

RECEIVED
OCT 27 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12/2)

CERTIFICATE OF DEATH

Reg. Dist. No. 09813 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 41 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
 How long in hospital or institution? 41 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AN
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 20 Cornhill Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I ✓

3. (a) FULL NAME

WILLIAM HENRY HOLLAND

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Muriel Holland
 7. Birth date of deceased (mo., day, yr.) 7-16-93 6. (c) If alive, give age 39 years
 8. AGE: Years 52 Months 3 Days 2 If less than one day hrs. min.

9. Birthplace Annapolis, Maryland
 (Town, county, and state)
 10. Usual occupation Chiropodist
 11. Industry or business
 12. Name William H. Holland
 13. Birthplace Maryland
 14. Maiden name Rosie Green
 15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm.
 Address Fort Howard, Maryland

17. Burial Date thereof 10/23/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory National Cemetery
 Location West of Annapolis, Md.
Edith L. Hicks (Name of person in charge of funeral)

18. Funeral director Ethel L. Hicks
 Address 43-45 Northwest Street

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1945 6:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 28, 1945 to October 19, 1945
 and that I last saw him alive on October 19, 1945

Immediate cause of death Heart Disease DURATION
Cause: Hypertension & Coronary Arterio- 1 Yr.
sclerosis, B.L: Cardiac enlargement, plus
Myocardial damage, Manif: Myo-
cardial insufficiency

Due to.....
 Other conditions Uremia, acute
Nephrosclerosis
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE A. M. Balter
A. M. BALTER, LT. COL., MFO. or CHIN. DIR.
 Address Fort Howard, Md. Date signed 10-19-45

RECEIVED
OCT 23 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

09814

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County BALTIMORECity or town TOWSON

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 2 days

Hospital, institution, or street address where death occurred:

THE SHEPPARD AND ENOCH PRATT HOSPITALHow long in hospital or institution? 3 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2035 E. Preston St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HORMES, EDNA SHEROLDS

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Harry W. Hormesdeceased

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 27, 1888

8. AGE: Years Months Days If less than one day

57 - 11 hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Clerk11. Industry or business Jewelry store12. Name Edward S. Brittain13. Birthplace Baltimore14. Maiden name Laura Snyder15. Birthplace Baltimore16. Informant HOSPITAL RECORDS

Address

17. Burial Date thereof 10/10/45

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory BaltimoreLocation Baltimore, Md.18. Funeral director William Cook, Inc.Address 1217 L. Lane St.19. 10-9 8-1 AWH

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 19 45 at 3:47 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 6 19 45 to October 8 19 45and that I last saw her alive on October 8 19 45

Immediate cause of death

Bronchitis pneumoniaDue to generalizedarteriosclerosis

Due to

Other conditions psychosis & cerebralarteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ross M. C. Chapman, M.D.

ROSS MCG. CHAPMAN, M.D. M. D. or other

Address TOWSON, MD. Date signed 10/8/45

DURATION

3 daysMark10 mo

Evidence for the change of
age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

09815

FILE No. G 98 OCT 23 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore

City or town Idenwyde
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

812 Register Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Vermont County _____

City or town Putney
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Claribel G. Houser

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife J. David Houser

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1893

6.(c) If alive, give age _____ years

8. AGE: Years 52 Months 1 Days 7 It less than one day _____ hrs. _____ min.

9. Birthplace Minnesota
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Charles L. Glidden

13. Birthplace Vermont

14. Maiden name Elizabeth Warkman

15. Birthplace Virginia

16. Informant Mrs. William S. Van Horn

Address 1745 Erhardt Rd, Balto. 21, Md.

17. Removal Date thereof Oct. 16, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meadsville, Pa.

Location Fleming & Kelley Funeral Home

18. Funeral director John Burne' Sons

Address Towson, Maryland

19. 10/15 45 A. M. Bacon
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14th 1945 at 4 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 27 1945 to Oct. 14 1945 and that I last saw him alive on Oct. 14 1945

Immediate cause of death Carcinomatosis

DURATION

Due to Carcinoma of breast
Left

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE A. Sedlacek M.D. or other

Address Towson 4 Md Date signed 10/14/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 18 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 months, 19 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?..... 2 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Harford
 City or town..... Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 701 N. Stoke Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

George Robert Howlett

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married
 6. (b) Name of husband or wife..... Rose Sanders Howlett
 6. (c) If alive, give age..... 69 years
 7. Birth date of deceased (mo., day, yr.)..... April 29, 1866
 8. AGE: Years..... 79 Months..... 5 Days..... 11 If less than one day..... hrs. Terminal min.

9. Birthplace..... Maryland
 (Town, county, and state)
Carpenter
 10. Usual occupation.....
 11. Industry or business..... Carpentering
 12. Name..... William Howlett
 13. Birthplace..... Maryland
 14. Maiden name..... Elizabeth Gilbert
 15. Birthplace..... Maryland
 16. Informant..... Hospital records
 Address..... Catonsville-28, Maryland

17. Burial Date thereof..... Oct 13-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Angel Hill Cem.
Havre de Grace Md
 Location.....
 18. Funeral director..... Pennington & Son
 Address..... Havre de Grace Md
 19. 10/10 19. 45
 (Date rec'd by registrar) N. C. Gardner Registrar Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 10 19. 45 at 2:50 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 21 19. 45 to October 10 19. 45
 and that I last saw him alive on October 10 19. 45

Immediate cause of death.....
Terminal broncho pneumonia DURATION..... 1 day

Due to..... auricular fibrillation 5 days

Due to..... Chronic Myocarditis Indef.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... No

Date of op.

Autopsy results..... No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... No Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where)?.....

Means of injury..... Injured at work?.....

23. SIGNATURE.....

Robert E. Gardner
Robert E. Gardner, M.D. M. D. or other
Catonsville-28, Md. Date signed..... 10/10/45

RECEIVED
OCT 22 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

09817

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Baltimore
 City or town..... Hydes
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

James Lewis Ison

3. (b) Social Security Number

-

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married
 8.(b) Name of husband or wife..... Laura Woods
 6.(c) If alive, give age..... 69 years
 7. Birth date of deceased (mo., day, yr.)..... August 17, 1867
 8. AGE: Years..... 78 Months..... 1 Days..... 30 If less than one day..... hrs. min.

9. Birthplace..... Franklinville, Baltimore Co., Md.
 (Town, county, and state)
 10. Usual occupation..... laborer
 11. Industry or business..... railroad

FATHER 12. Name..... ?
 13. Birthplace..... ?
 MOTHER 14. Maiden name..... Mary Jane ?
 15. Birthplace..... Baltimore Co., Md.

16. Informant..... Hospital Records
 Address..... Catonsville-28, Md.

17. Burial..... Burial Date thereof..... 10-18-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Harwood Cem.
 Location..... Taylor Ave

18. Funeral director..... Clarence Out for
 Address..... York Md.

19. Oct 17 19 45 C. W. H. Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 16 19 45 at 10:13 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 9 19 45 to October 16 19 45
 and that I last saw him alive on October 16 19 45

Immediate cause of death.....
Auricular fibrillation
 Due to..... Chronic myocarditis with
coronary occlusion
 Due to.....

Other conditions..... Hypertrophy of the prostate
with secondary cystitis
 (Include pregnancy within 9 months of death)
 Indef.

Major findings of operations.....
 Date of op.

Autopsy results..... As above.
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE..... Robert E. Gardner M. D. or other
Catonsville 28, Md.
 Address..... Date signed 10/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Arbutus, Balto CountyCity or town.....
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John George Jacobs

3. (b) Social Security Number

4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced widow.

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 1/11 January 3, 18758. AGE: Years 68 Months 9 Days 14 If less than one day

..... hrs. min.

9. Birthplace Balto
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name John E. Jacobs.13. Birthplace Germany14. Maiden name Louise J. Anna Jacobs15. Birthplace Md.16. Informant Edward Louison Laura Bennett JacobsAddress 2359 Wash Blvd Balto 124317. Burial Date thereof 10/12/45
(Burial, cremation, or removal of body) (month) (day) (year)Cemetery or crematory St PaulsLocation Grind Hill Park18. Funeral director Edward LouisonAddress 2359 Wash Blvd19. Oct 16 W OW Hudson
(Date rec'd by registrar) (month) (day) (year) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State 10/15-45 County Balto Co MdCity or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)Street No. 1243 Circle Drive
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1945 at 12:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 20, 1945 to October 15, 1945and that I last saw him alive on October 14, 1945

Immediate cause of death

Arteriosclerotic Cardiovascular DisCardiac decompensationDURATION 10 mos.10 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

Arteriosclerotic Cardiovascular Dis

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Earl Pass, M.D.

M. D. or other

Address 4001 Wilkins AveDate signed 10-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 40

1. PLACE OF DEATH:

County Bald Co
 City or town Baldwin Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Bald
 City or town Baldwin
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Norris H. James

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife

Etta F. James

7. Birth date of

deceased (mo., day, yr.)

Dec. 29 - 1872

6.(c) If alive, give age _____ years

8. AGE:

Years	Months	Days	It less than one day
<u>72</u>	<u>9</u>	<u>24</u>	_____ hrs. _____ min.

9. Birthplace

Harford Co. Md.
(Town, county, and state)

10. Usual occupation

Fruit grower

11. Industry or business

FATHER

12. Name

John L. James

13. Birthplace

Harford Co. Md.

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs Etta F. James

Address

Baldwin Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct 26 - 1945
(month) (day) (year)

Cemetery or crematory

Fork M. E. Cem

Location

Fork Md.

18. Funeral director

Clarence E. Arthur

Address

Fork Md.

19.

(Date rec'd by registrar)

19 45Clarence E. Arthur
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 24 1945 at 10:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 1944 to October 24 1945
and that I last saw him alive on October 24 1945

Immediate cause of death

Congestive Heart Failure 5 mos.

DURATION

Due to

arteriosclerotic
Heart Disease2 yrs

Due to

Other conditions

Osteo-Arthritis3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Clarence E. Arthur
Fork Md.

M. D. or other

Address

Date signed 10/25/45

CERTIFICATE OF DEATH

RECEIVED
NOV 3 1945
DEATH V. 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09820

P

Reg. Dist. No.

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Months
Hospital, institution, or street address where death occurred: North Bend & Food Convalescent Home Edmonston Ave
How long in hospital or institution? 3 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1200 Chesapeake Ave
(If rural, give LOCATION)
2.(a) If veteran, name war Yes ☒

3. (a) FULL NAME Nannie Payne Jester 3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Reuben Thomas Jester
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) September 5, 1864
8. AGE: Years 81 Months 1 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
MOTHER FATHER
12. Name Joseph Baker Jordan
13. Birthplace Virginia
14. Maiden name Kate Greenstreet
15. Birthplace Virginia
16. Informant Mrs. Nellie Donaldson
Address Severn, Maryland
17. Burial Burial Date thereof 10-10-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Anne Arundel County Md.
18. Funeral director George L. Schwab
Address 2101 Frederick Avenue
19. 10-9-85 H. H. Hester
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
2D. DATE OF DEATH October 6 19 45 at 2:45 P
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 14 19 44 to Oct. 6 19 45
and that I last saw her alive on Oct. 4 19 45
Immediate cause of death Broncho-pneumonia DURATION 5 days
Due to _____
Due to _____
Other conditions cerebral hemorrhage 1 year
(Include pregnancy within 8 months of death)
Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE Harry Deibel M.D. M. D. or other 10/9/45
Address 1226 Hanover St Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 304

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 7 years, 9 mos., 18 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?..... 7 years, 9 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 1415 North Bond Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... None ✓

3. (a) FULL NAME

(James Johnson) (Charles James Johnston)

3. (b) Social Security Number
None

4. Sex..... Male
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Divorced

6. (b) Name of husband or wife..... Unknown
 7. Birth date of deceased (mo., day, yr.)..... #### April, 1902
 6. (c) If alive, give age..... 7 years

8. AGE: Years..... 43 # 43 Months..... # 6 Days..... # 9 If less than one day..... #### min.

9. Birthplace..... Baltimore
 (Town, county, and state)
 10. Usual occupation..... Circular distributor

11. Industry or business..... Advertising

12. Name..... James? Johnson
 13. Birthplace..... Baltimore, Md.

14. Maiden name..... Margaret # Archer
 15. Birthplace..... Baltimore Md.

16. Informant..... Hospital records
 Address..... Catonsville-28, Maryland

17. Burial Date thereof..... II/I/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... New Cathedral
Edmondson Avenue
 Location.....

18. Funeral director..... George J. Ruth, Inc.
 Address..... 1735 Harford Avenue

19. Oct. 30 19 45 A. H. Hedrick
 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 29 1945 at 1:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 11 1938 to October 29 1945
 and that I last saw him alive on October 29 1945

Immediate cause of death.....
Terminal pneumonia 72 hrs.
General paresis Indef.

Due to.....
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results..... None done
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... Robert E. Gardner, M.D. M. D. or other
 Address..... Catonsville-28, Md. Date signed..... 10/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... Baltimore
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 4 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?... 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County...
 City or town... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 25 North Smallwood Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Thomas Kelly

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife... Annie Manion (deceased)
 7. Birth date of deceased (mo., day, yr.) November 1859 6.(c) If alive, give age... years
 8. AGE: Years 85 Months 11? Days If less than one day hrs. min.

9. Birthplace... Ireland
 (Town, county, and state)
 10. Usual occupation... Laborer
 11. Industry or business None
 12. Name... John Kelly
 13. Birthplace... Ireland
 14. Maiden name... Mary ---
 15. Birthplace... Ireland

16. Informant... Hospital Records -
 Address... Catonsville, 28, Md.

17. Burial Date thereof... 10/10/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... New Catholic Cemetery
4300 Old Frederick Road
 Location... John J. Boraw & Son

18. Funeral director... John J. Boraw & Son
 Address... 9003 Hollins Street

19. October 9, 1945 aw Thedink
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... October 7, 1945 19... at 11:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 3, 1945 to October 7, 1945
 and that I last saw him alive on October 7, 1945

Immediate cause of death... Acute exacerbation DURATION
chronic myocardial insufficiency 2 hours

Due to... Arteriosclerotic C-V-R
Disease Indef.

Due to...
 Other conditions... Primary anemia

(Include pregnancy within 3 months of death)

Major findings of operations...
 Date of op....

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... Henry C. A. Mead, M.D.
Henry C. A. Mead, M.D. or other
 Address... Catonsville, 28, Md. Date signed... 10/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

09823 38
Reg. Dist. No.

1. PLACE OF DEATH: BALTIMORE
County -----
City or town TOWSON
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: THE SHEPPARD AND ENOCH PRATT HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 1 month, 6 days
Stay in this community (yrs., or mos., or days) 1 month, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State District of Columbia County -----
City or town Washington, 9 Ward No. -----
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 2733 Ontario Road, N. W.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR -----

3. (a) FULL NAME

KING, CORA ADELE

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife -----
6 (c) If alive, give age ----- years
7. Birth date of deceased (mo., day, yr.) October 12, 1872
8. AGE: Years 73 Months ----- Days 19 If less than one day ----- hrs. ----- min.

9. Birthplace Baltimore City, Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business -----
12. Name John T. King
13. Birthplace Maryland
14. Maiden name Cora Fullings
15. Birthplace New Jersey

16. Informant HOSPITAL RECORDS
Address -----
17. Burial Date thereof Nov: 7-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory London Park Cemetery
Location 3801 Frederick Ave
18. Funeral director John O. Mitchell Sons
Address 1900 Eastern Bldg
19. 11-2-45 Registrar D. W. Mearns
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 19 45 at 6:35 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25 19 45, to Oct. 31 19 45
and that I last saw her alive on October 31 19 45

Immediate cause of death
Carcinoma of the Rectum
2 multiple metastases

Due to -----
Due to -----

Other conditions Paranoid Psychosis 30 yrs +
(Include pregnancy within 3 months of death)

Major findings: -----
Of operations -----
Of autopsy Confirming above

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ----- Date of -----
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury ----- Injured at work? -----

23. SIGNATURE Ross M. C. Chapman M.D.
ROSS MCC. CHAPMAN, M. D. M. D. or other
Address TOWSON, MD. Date signed 10/31/45

MARGIN RESERVED FOR BINDING

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

09824

CERTIFICATE OF DEATH



Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)Street No. Kingsley Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William E. King

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

MarriedB.(b) Name of husband or wife Laura V. King

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 18828. AGE: Years 62 Months 11 Days 28 If less than one day
hrs. min.9. Birthplace Carroll Co.
(Town, county, and state)10. Usual occupation Retired grocery clerk

11. Industry or business

12. Name Jessie I. King13. Birthplace Carroll Co.14. Maiden name Frances Spurrier15. Birthplace Carroll Co.18. Informant Mrs. Laura V. KingAddress Owings Mills17. Burial Date thereof Nov. 2, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory All SaintsLocation Reisterstown, Md.18. Funeral director J.F. Eline & SonsAddress Reisterstown, Md.19. Nov. 2 19 45 MARY B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 19 45 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-3- 19 36 to 10-31 19 45and that I last saw him alive on October 31 19 45Immediate cause of death Cervical Phlebotomy

DURATION

2 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) Re (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE D. D. Caplan, M.D. M. D. or otherAddress Reisterstown, Md. Date signed 10-31-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 5 1945

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

09825

★ Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mo., 5 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 2 mo., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2904 Parkwood Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war No. ✓

3. (a) FULL NAME

Samuel Klepfish

3. (b) Social Security Number

Not known

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) ? 1886 6. (c) If alive, give age _____ years

8. AGE: Years 59 Months ? Days ? If less than one day _____ hrs. _____ min.

9. Birthplace Poland
 (Town, county, and state)

10. Usual occupation Tailor11. Industry or business Tailor Shop12. Name Moses Klepfish13. Birthplace Poland14. Maiden name Freida ?15. Birthplace Poland16. Informant Hospital records

Address

17. Burial Date thereof Oct. 14 - 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hebrew Mt. CarmelLocation Berman Hill Rd.18. Funeral director Rich Lewis Inc.Address 1439 E. Patton St.

19. 10/14/45 W. C. Bridges Catonsville
 (Date rec'd by registrar) (Signature) (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 8, 1945 to Oct. 13, 1945
 and that I last saw him alive on Oct. 13, 1945

Immediate cause of death Chronic Myocarditis DURATION Indef.

Due to Arteriosclerosis Indef.

Due to

Other conditions Hemiplegia Since 1937

(Include pregnancy within 8 months of death)

Major findings of operations No

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert E. Gardner M.D.

Catonsville 10/14/45
 Address Date signed

RECEIVED

OCT 22 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09826

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BALTIMORE

City or town SPARROWS POINT
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Edgemere
(If outside city or town limits, write RURAL and give nearest town)

Street No. Stanows Pt. Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Koukounaris
John KOKONARIS

3. (b) Social Security Number

169-01-8256

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: 56 Years Months Days It less than one day hrs. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Acrodis Corp.

12. Name Unknown

13. Birthplace Greece

14. Maiden name Unknown

15. Birthplace Greece

16. Informant Stephen Solomon

Address Edgemere, Md.

17. Burial Date thereof Oct. 10-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greek Orthodox

Location Stander Mill Road

18. Funeral director John J. Connolly

Address 4886 Eastern Ave. Edges

19. Oct. 10-45 Registrar John J. Connolly

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8-45 19. at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Davis, M.D.

Address W. B. Davis, M.D.

Date signed 10/8/45

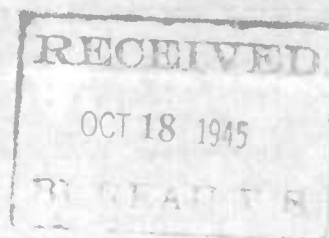
MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED FEDERAL BUREAU OF INVESTIGATION

U.S. DEPARTMENT OF JUSTICE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Inf. re place of death by phone from Hood Nursing Home. 11-5-45ans

Inf. re place of death by phone from Hood Nursing Home. 11-5-45ars

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 927

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH: County <u>2201 Edmondson and</u> City or town <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>few months</u> Hospital, institution, or street address where death occurred: <u>Hood Nursing Home 1118 1/2 years</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md</u> County _____ City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>3719 Echadale</u> and _____ (If rural, give LOCATION) 2.(c) If veteran, name war _____							
3. (a) FULL NAME <u>Frances V. Kowalski</u>				3. (b) Social Security Number							
4. Sex <u>F</u>		5. Color or race <u>W</u>		6. (a) Single, married, widowed, or divorced <u>Single</u>							
6. (b) Name of husband or wife						MEDICAL CERTIFICATION					
7. Birth date of deceased (mo., day, yr.) <u>Oct. 24 1919</u>						2D. DATE OF DEATH <u>Oct 18 1945</u> at <u>4A</u>					
8. AGE: Years <u>25</u> Months <u>11</u> Days <u>28</u> If less than one day _____ hrs. _____ min.						21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Aug 1 1945</u> to <u>Oct 18 1945</u> and that I last saw her alive on <u>Oct 17 1945</u>					
9. Birthplace <u>New Britain Conn</u> (Town, county, and state)						Immediate cause of death <u>Chr Myocarditis</u>					
10. Usual occupation <u>house</u>						Due to <u>Myxomatous Polypoid</u>					
11. Industry or business						Due to <u>Polypoid</u>					
12. Name <u>Leo Kowalski</u>						Other conditions					
13. Birthplace <u>Plymouth Penn</u>						(Include pregnancy within 8 months of death)					
14. Maiden name <u>Helen Ligniski</u>						Major findings of operations <u>Myxomatous Polypoid</u>					
15. Birthplace <u>Baltimore Ind</u>						Date of op. <u>Mar 1945</u>					
16. Informant <u>Mrs Helen Gran Mother</u>						Autopsy results <u>none</u>					
Address <u>3719 Echadale and</u>						PHYSICIAN: Please underline the cause to which death should be charged statistically.					
17. Burial (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>10 20 45</u> (month) (day) (year) Cemetery or crematory <u>Holy Rosary Cem</u>						22. VIOLENCE: If death was due to external causes, fill in the following:					
Location <u>Baltimore County</u>						Accident, suicide, or homicide					
18. Funeral director <u>John W. Weber</u>						Where did injury occur?					
Address <u>481 S. Chester Street</u>						Injured at home, farm, industry, public place (where?)					
19. 10-19 45 (Date rec'd by registrar)						Means of injury					
Registrar						Injured at work?					
23. SIGNATURE <u>James H. Houser</u>						M. D. or other					
Address <u>Catonsville</u>						Date signed <u>10/18</u>					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1912)

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore
 City or town Jexas
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

7 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Jexas Ward No.
 (If outside city or town limits, write RURAL NEAR and give town)

Street No.
 (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Edgar Louis Kraftt

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Divorced

6 (b) Name of husband or wife

Fannie (nee Hindman)

6 (c) If alive, give age

54 years

7. Birth date of deceased (mo., day, yr.)

Mar. 25, 1886

8. AGE:

Years

Months

Days

If less than one day

59

6

18

hrs.

min.

9. Birthplace

York Co., Penn.
(town, county, and state)

10. Usual occupation

Hotel Keeper

11. Industry or business

FATHER

12. Name

Joseph Kraftt

13. Birthplace

York Penn.

MOTHER

14. Maiden name

Rosetta Fisher

15. Birthplace

York, Penn.

16. Informant

Mrs. Gladys M. Allison
Jexas, Md.

Address

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof Oct. 15, 1945
(month) (day) (year)

Cemetery or crematory

Poplar

Location

Cockeysville, Md.

18. Funeral director

Landon M. Brooks

Address

Sparks, Md.

19.

Oct. 15 45
(Date rec'd by registrar)

Wilmer C. Ensor

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 12

at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-2-44 to Oct 12, 1945

and that I last saw him alive on

Oct 12, 1945

Immediate cause of death

myocarditis
chronic - decompensated

Due to

hypertension

Due to

arteriosclerosis

Other conditions

chronic nephritis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

346

PHYSICIAN

Please underline
 the cause to which
 death should be
 charged statisti-
 cally.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

James L. Saffell

Address

Reisterstown Md

M. D. or other

Date signed 10/13/45

RECEIVED

OCT 16 1945

BUREAU V. &

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 33

CERTIFICATE OF DEATH

09829

1. PLACE OF DEATH:

(a) County Baltimore
 (b) City or town Reisterstown
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution:
Ret. Pleasant
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
 (e) Length of stay in this community (yrs., mos., or days) _____

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County _____
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 2562 Druid Park Drive
 (If rural give location) ✓
 (e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME

Harold Krakowsky

3 (b) If veteran, name war

3 (c) Social Security

No. 053-18-0557

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Sept. 14, 1925

8. AGE:

Years

Months

Days

If less than one day

20

1

12

hr.

min.

9. Birthplace

Brooklyn, New York
 (Town, county, and state)

10. Usual occupation

Student

11. Industry or business

MOTHER FATHER

12. Name

Samuel Krakowsky

13. Birthplace

U.S.A.

14. Maiden Name

Beatrice Miller

15. Birthplace

U.S.A.

16 (a) Informant

Beatrice Krakowsky

(b) Address

2562 Druid Park Drive

17 (a)

Burial

(b) Date thereof

10-28-45

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Reisterstown
Phil. Rd. + Hemetown Ave
Just down the

18 (a) Funeral director

(b) Address

1439 E. Balto. St.

19 (a) Oct. 17, 1945

(Date rec'd by registrar)

(b)

Dr. W. Hedrick
Ed

Registrar

MEDICAL CERTIFICATION

20. Date of death

October 26, 1945, at 9³⁵ P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 26, 1945, to Oct. 26, 1945, and that I last saw him alive on Oct. 26, 1945.

Immediate cause of death

Myocardial Failure

Due to Primary Tuberculosis

Due to Pulmonary Tuberculosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy Primary Tuberculosis

Duration

4 mos.

2 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature

Albert J. Shuei M.D.

M. D. or other

Address Reisterstown, Md. Date signed Oct. 26, 1945

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

09830

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.City or town Bundalk
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto.City or town Bundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 30 Township Rd.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

MARIE KRATZ (KENNY)

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Howard H. Kratz6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) July 19th - 18838. AGE: Years 62 Months 2 Days 14 If less than one day
hrs. min.9. Birthplace Baltimore
(Town, county, and state)10. Usual occupation Homemaker

11. Industry or business

12. Name Earnest Holf13. Birthplace md.14. Maiden name Susan Kratz15. Birthplace Baltimore16. Informant Howard H. KratzAddress 30 Township Rd. Bundalk17. Burial Date thereof Oct. 4 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak LawnLocation Eastern Boulevard18. Funeral director John G. ConnellyAddress Cessex, Md.19. 10/4/45 John G. Connelly
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 19 45 at 7 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 44 to Oct 1 19 45
and that I last saw him alive on Oct 1 19 45Immediate cause of death Cerebral hemorrhageDue to ArteriosclerosisDue to chronic myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard H. Kratz M.D.Address 2 Township Rd. Bundalk Md. Date signed 10/4/45

DURATION

16 months10 yrs5 yrs

OCT-4 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

69831

★ Reg. Dist. No. 32

1. PLACE OF DEATH:

County Balto.
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Robb Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 365 Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CATHERINE A. LAMBERT

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

John C. Lambert

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

May 1959

8. AGE:

Years

86

Months

5

Days

If less than one day

hrs.

min.

9. Birthplace

Bellefonte, Pa.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

James B. Clark

13. Birthplace

Ireland

MOTHER

14. Maiden name

Maria Green

15. Birthplace

England

16. Informant

Mr. Charles B. Clarke

Address

2302 Roslyn Ave.

17.

Burial

Date thereof

10/15/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetary or crematory

Druid Ridge Cen.

Location

Pikesville, Md.

18. Funeral director

WM. J. TICKNER & SONS

Address

Balto., Md.

19.

10-13-45

(Date rec'd by registrar)

Dr. E. E. Nichols
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1945 at 6:00 a.m.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 11/45 to Oct 12/45
and that I last saw him alive on October 10/45

Immediate cause of death

Myocardial Sclerosis

Due to

Senility

Due to

General Asthenia

Other conditions

General Asthenia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. E. Nichols
Pikesville, Md.

M. D. or other

Address

Date signed

Oct 13-45

RECEIVED

OCT 16 1945

BUREAU V.F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH



Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
 How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 619 Harlem Lane
 (If rural, give LOCATION)
 2. (a) If veteran, name war PTE

3. (a) FULL NAME

FELIX D. LAYTON

3. (b) Social Security Number

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Married	
6. (b) Name of husband or wife <u>Margaret V. Layton</u>			
7. Birth date of deceased (mo., day, yr.) <u>8-4-1886</u>			
8. AGE: Years 59	Months 2	Days 6	6. (c) If alive, give age <u>48</u> years If less than one day hrs. min.
9. Birthplace <u>Ohio</u> (Town, county, and state)			
10. Usual occupation <u>Unemployed</u>			
11. Industry or business			
FATHER	12. Name <u>Charles Layton</u>		
	13. Birthplace <u>Landsdown, Maryland</u>		
MOTHER	14. Maiden name <u>Anna Davis</u>		
	15. Birthplace <u>Virginia</u>		

16. Informant Clinical Records, Vets. Adm. Fac.
 Address Fort Howard, Maryland

17. Burial Date thereof 10/15/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematorium U.S. National
 Location Ft. Howard, Md.

18. Funeral director Edward M. Maffei
 Address Catonsville, Md.

19. 10/15 19 45
 (Date rec'd by registrar) N.C. Rodgers

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1945 at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 28, 1945 to October 10, 1945
 and that I last saw him in alive on October 10, 1945

Immediate cause of death	DURATION
<u>Disease of the Heart, Hypertension</u>	<u>3 Mos. Plus</u>
<u>Myocardial Insufficiency</u>	<u>Unknown</u>
<u>Nephritis, interstitial, chr.</u>	<u>Unknown</u>

Due to.....
 Other conditions Pneumonia, lobular 1 Week
Blindness, bilateral 12 Yrs.
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE A. M. BALTER
A. M. BALTER, LT. COL., M.C. CLIN. DIR.
 Address Ft. Howard, Maryland Date signed 10-11-45

RECEIVED

NOV 1 1945

KOREAN V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

09833

Reg. Dist. No. 57

1. PLACE OF DEATH:
County Baltimore
City or town Texas
(If outside city or town limits, write RURAL and give nearest town)
How long to above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Baltimore
City or town Texas
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME Maurice E. Leech 3. (b) Social Security Number _____

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
8. (b) Name of husband or wife Elizabeth Leech
7. Birth date of deceased (mo., day, yr.) Jan 1 1886 8. (c) If alive, give age 56 years
8. AGE: Years 59 Months 9 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Harford Co MD
(Town, county, and state)

10. Usual occupation merchant

11. Industry or business Service Station

12. Name Mr Leech

13. Birthplace MD

14. Maiden name Margaret Cochran

15. Birthplace Harford Co MD

16. Informant Mrs Elizabeth Leech

Address Texas

17. Burial Date thereof 10/12/45
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St Josephs

Location Texas Balto Co MD

18. Funeral director Martha E. Kurtz

Address Jamettsville MD

19. Oct. 9 19 45 Wilmer C. Ensor Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH Oct 8 19 45 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 8 19 45 to Oct 8 19 45 and that I last saw him alive on Oct 8 19 45

Immediate cause of death Coronary Thrombosis DURATION 2 hrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wilmer C. Ensor M.D. M. D. or other _____

Address Cochansville MD Date signed 10/9/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 10 1945
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BALTIMORE
 City or town Bundick
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7310 Market Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Bundick
(If outside city or town limits, write RURAL and give nearest town)Street No. Church Road
(If rural, give LOCATION)2.(a) If veteran, name war W

3. (a) FULL NAME

Lora A Lewis

3. (b) Social Security Number

none4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Myssie's7. Birth date of deceased (mo., day, yr.) Nov 14, 1876 6. (c) If alive, give age years8. AGE: Years 68 Months 11 Days 1 If less than one day hrs. min.9. Birthplace Anchorage, Alaska
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Jessie Liggett13. Birthplace Baltimore

14. Maiden name

15. Birthplace

16. Informant Donald E LewisAddress 7310 Market Ave17. (Burial, cremation, or removal). Which? 10/18/45
Date thereof (month) (day) (year)Cemetery or crematory PINE GROVELocation Baltimore County MD18. Funeral director Wm. W. LeeAddress 1217 1/2 Paul St. Baltimore19. 10-76-45 Registrar(Date rec'd by registrar) 19 45

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 19 45 at 10:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 2 19 45 to Oct 15 19 45and that I last saw her alive on Oct 15 19 45Immediate cause of death A-S-C-V-Disease

DURATION

5 yrs

Due to

Due to

Other conditions Cholelithiasis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M B Davis MD

M. D. or other

Address Bundick, MD Date signed 10/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Owings Mills, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos 18 days
 Hospital, institution, or street address where death occurred:
Rosewood State Training School.
 How long in hospital or institution? 2 mos 19 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County 18
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1716 W. Baltimore St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Faith Rosalie Roxanna Lockerman.

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) February 21, 1939. 6. (c) If alive, give age years

8. AGE: Years 6 Months 7 Days 24 If less than one day hrs. min.

9. Birthplace Baltimore Maryland
 (Town, county, and state)

10. Usual occupation None11. Industry or business None.12. Name Charles Mills Lockerman13. Birthplace Baltimore.14. Maiden name Mary Melvina Hazzer15. Birthplace Kent Co. Maryland.16. Informant Rosewood State Training SchoolAddress Owings Mills Md. Record17. Burial Date thereof Oct. 17, 1945

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Loudon Park.Location Frederick Road, Baltimore18. Funeral director John F. Denny, Inc.Address 715 Light St.19. Oct 18 19 45 Dr. Hedrich

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 19 45 at 2³⁰ A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 19 45 to October 15 19 45 and that I last saw him alive on October 15 19 45.

Immediate cause of death

Due to Broncho-pneumonia 2 days.Due to Bronchitis 3 days.Due to Nasopharyngitis 4 days.Other conditions Infantile Dilegia since birthP.T.T. Mal Epilepsy. 2 mos 18 days.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Isabel H. Th. Clinton M.D.Address Rosewood-Owings Mills Md. Date signed Oct 15/45

M. D. or other

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH:

County Baltimore
City or town Mount Wilson, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 2 mos., 27 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 2 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 342 Folcroft St., Balto., Md.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Marianna Lombardi

3. (b) Social Security Number

Unknown

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) September 18, 1927 5. (c) If alive, give age _____ years

8. AGE: Years 18 Months 1 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Sales Clerk

11. Industry or business _____

FATHER 12. Name Louis Lombardi 13. Birthplace Italy

MOTHER 14. Maiden name Anna Patella 15. Birthplace Italy

16. Informant Marianna Lombardi
Address 342 Folcroft St., Balto., Md.

17. Burial Date thereof Oct. 26, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer Cemetery

Location 4430 Belair Rd., Balto., Md.

18. Funeral director Frank Della Noce

Address 322 Trinity St., Balto., Md.

19. Oct. 22, 1945 Earl T. Webster
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1945, 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25, 1945 to Oct. 22, 1945 and that I last saw her alive on October 22, 1945

Immediate cause of death Pulmonary Tuberculosis DURATION 5 Mos.

Due to Tubercle Bacilli

Due to _____

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Autopsy results No autopsy Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other

Address Mt. Wilson, Md. Date signed Oct. 22, 1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAINTAIN STATE OF MENTAL

CERTIFICATE OF DEATH

DEATH OF PERSONS IN MENTAL

DEATH OF PERSONS

DEATH OF PERSONS

RECEIVED

OCT 25 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

09837

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 9 days

3. (a) FULL NAME

Harry E Lusby

4. Sex

Male5. Color or race White6. (b) Name of husband or wife Edith Bean6. (c) If alive, give age 67 years7. Birth date of deceased (mo., day, yr.) May 13, 18838. AGE: Years 62 Months 4 Days 23 If less than one day9. Birthplace Brandywine Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Richard Lusby13. Birthplace Maryland14. Maiden name Georgiana Stansberry15. Birthplace Maryland16. Informant Spring Grove State Hosp. RecordsAddress Catonsville, Maryland17. Burial Date thereof Oct 9-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Paul's B.E. CemeteryLocation Waldorf, Md18. Funeral director Waldorf & RyanAddress Waldorf Md19. 10/6 45 N.C. Pydie
(Date rec'd by registrar) (year) (month) (day) (Signature)Address Spring Grove State HospitalDate signed Oct 6, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 19 45, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 28 19 45 to October 6 19 45and that I last saw him alive on October 6 19 45Immediate cause of death Pulmonary EdemaDue to Arteriosclerotic Heart DiseaseOther conditions Generalized ArteriosclerosisOther conditions Paralysis Agitans

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert E. Garandine

M. D. or other _____

Address Spring Grove State HospitalDate signed Oct 6, 1945

RECEIVED
OCT 22 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

9 Liberty Pky.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 9 Liberty Parkway
(If rural, give LOCATION)2.(a) If veteran, name war No

3.(a) FULL NAME

Ella Lynch

3.(b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FWSingle

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 18798. AGE: Years Months Days If less than one day
36 6 8 _____ hrs. _____ min.9. Birthplace Baltimore County, Md.
(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

12. Name William Rogers Lynch13. Birthplace Maryland14. Maiden name Sarah F. Grace15. Birthplace Baltimore County, Md.16. Informant Mr. William G. LynchAddress 9 Liberty Parkway, Dundalk17. Burial Date thereof 10/3/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak Lawn CemeteryLocation Baltimore, Maryland18. Funeral director HENRY SANDER & SONS, INC.Address NORTH AVE? & BROADWAY19. Oct 5 19 45 AW Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 19 45 at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 19 45, to Oct 4 19 45and that I last saw him alive on Oct 4 19 45Immediate cause of death CoronaryThrombosisDUE TO Hypertension

DUE TO _____

DUE TO _____

DUE TO _____

DUE TO _____

DUE TO _____

DUE TO _____

DUE TO _____

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DUE TO _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 10 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?..... 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
2517 North Charles Street
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... 12 ✓

3. (a) FULL NAME

Harriet Magraw

3. (b) Social Security Number

none

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Single
-------------------------	----------------------------------	--

B.(b) Name of husband or wife..... -
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) May 30, 1875
 8. AGE: Years Months Days If less than one day
70 4 1 hrs. min.

B. Birthplace..... Cecil County, Maryland
 (Town, county, and estate)
 10. Usual occupation..... Unemployed
 11. Industry or business..... None
 FATHER
 12. Name..... Stephen C. Magraw
 13. Birthplace..... Ohio
 MOTHER
 14. Maiden name..... Jane Webster
 15. Birthplace..... Lutherville Md
 16. Informant..... Hospital records
 Address..... Catonsville-28, Maryland

17. Burial Date thereof..... 10/4/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... West Nottingham
 Location..... Cecil Co. Md.
 18. Funeral director..... William Cook Inc
 Address..... 1217 St. Paul st.
 19. Oct 3 19 45 aw Magraw
 (Date rec'd by registrar) Registrar adk

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 1 19 45, at 6:27 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 21 19 45, to October 1 19 45
 and that I last saw her alive on October 1 19 45

Immediate cause of death.....
Terminal broncho pneumonia
 Due to..... Chronic myocardial insufficiency
 Due to..... Generalized arteriosclerosis
 Other conditions.....
 (Include pregnancy within 8 months of death)

DURATION
24 hours

Major findings of operations.....
 Date of op.....
 Autopsy results..... As above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
 23. SIGNATURE..... Robert E. Gardner M.D.
Catonsville-28, Md.
 Address..... Date signed..... 10/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-6

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
 How long in hospital or institution? 1 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 209 N. Mount St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WM-I ✓

3. (a) FULL NAME

ALBERT J. MASSEY

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife Single
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) January 7, 1892
 8. AGE: Years 53 Months 8 Days 26 If less than one day hrs. min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Isaac Massey
 13. Birthplace Maryland

MOTHER 14. Maiden name Margaret Massey
 15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Fac.
Fort Howard, Maryland
 Address

17. Burial Date thereof 10-9-'45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
Baltimore, Md.
 Location

18. Funeral director Katie Williams
322 N. Schroeder, Balto., Md.
 Address

19. Oct 9 45 Am Medical
 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1945 at 11:25 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 2, 1945 to October 3, 1945 and that I last saw him alive on October 3, 1945

Immediate cause of death Tuberculosis, chr. pul. far adv.
active III DURATION 12 Months

Due to

Due to

Other conditions Hernia, ing. right

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? Yes

23. SIGNATURE Am Medical
A.M. BALTER, LT. COL., M.C.D. GEN. DIR.
Fort Howard, Md. Address Date signed 10-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

CERTIFICATE OF DEATH

09841

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 mos., 26 days

Hospital, institution, or street address where death occurred:

Veterans Administration, Fort Howard, Md.How long in hospital or institution? 4 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County 00City or town Pasadena
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION) ✓2.(a) If veteran, name war World War

3. (a) FULL NAME

HOBERT L. McMAHAN

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Vera McMahan7. Birth date of deceased (mo., day, yr.) August 21, 18978. AGE: Years 48 Months 1 Days 26 If less than one day

.....hrs.min.

9. Birthplace North Carolina
(Town, county, and state)10. Usual occupation Farmer or carpenter

11. Industry or business

12. Name Thomas McMahan13. Birthplace North Carolina14. Maiden name Amley Hall15. Birthplace North Carolina16. Informant Clinical Records, Veterans Administration, Fort Howard, Maryland17. Burial Date thereof Oct 22/1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WashingtonLocation Northside Cemetery18. Funeral director A. J. O'BrienAddress 4644 York Ave19. 10/18/45 A. W. Hedrick
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH October 17 19 45 at 10:30 am21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21 19 45 to October 17 19 45and that I last saw him alive on October 17 19 45Immediate cause of death Multiple myelomaDURATION 10 mos.

Due to

Due to

Other conditions Bronchopneumonia 1 dayAnemia, secondary

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE A. M. BALTERAddress VAF, Fort Howard, Md. Date signed 10/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
City or town Rockland, Brooklandville P.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Falls Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Rockland, Brooklandville P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Falls Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN EDWARD MERRYMAN

3. (b) Social Security Number

218-07-7124

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Mary Elizabeth Merryman

6. (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) August 1, 1863

8. AGE: Years Months Days If less than one day
82 2 18 hrs. min.

9. Birthplace Butler, Balto. Co., Md.
(Town, county, and state)

10. Usual occupation Miller-Bleach mill

11. Industry or business Retired

12. Name Jarrett Merryman

13. Birthplace Maryland

14. Maiden name wife

15. Birthplace Butler, Balto. Co., Md.

16. Informant Mrs. Edna Wheatley

Address Rockland, Brooklandville, Md.

17. Burial Date thereof Oct. 21, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Prospect Hill Cemetery

Location Towson, Maryland

18. Funeral director John E. Burns, Solo

Address Towson, Maryland

19. (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1945, at 2:00 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15, 1945, to Oct. 18, 1945

and that I last saw him alive on Oct. 18, 1945

Immediate cause of death Myocardial infarction

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel H. Burns, Solo

M. D. or other

Address St. 110 Park Ave

Date signed Oct. 19, 1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 5 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09843

Reg. Dist. No. 30

1. PLACE OF DEATH: County..... <u>Baltimore</u> City or town..... <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>1 year, 8 months, 27 days</u> Hospital, institution, or street address where death occurred: <u>Spring Grove State Hospital</u> How long in hospital or institution? <u>1 year, 8 months, 27 days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>St. Mary's</u> City or town..... <u>Leonardtown</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Lilly Mitchell</u>				3. (b) Social Security Number -			
4. Sex <u>female</u>		5. Color or race <u>white</u>		6. (a) Single, married, widowed, or divorced <u>single</u>			
6. (b) Name of husband or wife <u>no</u>							
7. Birth date of deceased (mo., day, yr.) <u>August 2, 1898</u>							
8. AGE: Years <u>47</u>		Months <u>2</u>		Days <u>27</u>		If less than one day hrs. min.	
9. Birthplace <u>Oconomowoc, Wisconsin</u> (Town, county, and state)							
10. Usual occupation <u>housekeeper</u>							
11. Industry or business <u>home</u>							
FATHER							
12. Name <u>Bertram Mitchell</u>							
13. Birthplace <u>New York</u>							
MOTHER							
14. Maiden name <u>Nattie Buck</u>							
15. Birthplace <u>Wisconsin</u>							
16. Informant <u>Hospital Records</u> Address..... <u>Catonsville 28, Md.</u>							
17. (Burial, cremation, or removal, Which?) <u>Burial</u> Date thereof..... <u>10-31-45</u> (month) (day) (year) Cemetery or crematory..... <u>St. Pauls</u> Location..... <u>Leonardtown, Md</u>							
18. Funeral director <u>H. C. Mattingley Sons</u> Address..... <u>Leonardtown, Md.</u>							
19. (Date rec'd by registrar) <u>10/30/45</u> Registrar..... <u>Carroll</u>							
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>October 29, 1945</u> at <u>2:00a</u>							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>February 2, 1944</u> to <u>October 29, 1945</u> and that I last saw him/her alive on <u>October 29, 1945</u> Immediate cause of death..... <u>Coronary Occlusion</u> Due to..... <u>Sudden Death</u> Other conditions..... <u>Lung</u> (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... <u>As above</u> PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where)? Means of injury..... Injured at work?							
23. SIGNATURE <u>Gertrude E. [illegible]</u> M. D. or other..... Address..... <u>1010 [illegible]</u> Date signed..... <u>10-29-45</u>							

RECEIVED

NOV 1 1945

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 302

CERTIFICATE OF DEATH

09844
Reg. Dist. No. 412

1. PLACE OF DEATH:

County Baltimore
City or town Baltimore - 26 - Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
442 Criole Avenue
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) 37 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
City or town Baltimore Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 442 Criole Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Henry Moore

3. (b) Social Security Number

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 21, 1887

8. AGE: Years 58 yrs. Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Servant

11. Industry or business _____

12. Name unknown

13. Birthplace "

14. Maiden name "

15. Birthplace "

16. Informant Mrs. Mary Pospisil

Address 440 Criole Avenue

17. Burial Date thereof 10/15/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium xxx Mount Auburn

Location Annapolis Ave. & Hollins Ferry Road

18. Funeral director Charles E. Schimunek

Address 2601-03 E. Madison Street

19. Oct 15 19 45 AW Hedrick
(Date rec'd by registrar) Registrar oct

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14th 19 45, at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 19 37, to Oct 14 19 45
and that I last saw him alive on Oct 12 19 45

Immediate cause of death Syphilitic Cardiovascular Disease
Coronary Thrombosis
Coronary Atherosclerosis

Due to _____

Other conditions None

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy None

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles E. Schimunek M. D. or other _____

Address 8428 E. Ave. Date signed 10-14-45

DURATION
12-24-37
10-72-45
10-14-45

PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09845

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore
 City or town Relay, 27, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 days
 Hospital, institution, or street address where death occurred:
Relay Sanitarium
 How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County _____
 City or town 2814 Grantley Road
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Baltimore, Md.
 (If rural, give LOCATION)
 2 (a) If veteran, name war _____ V

3. (a) FULL NAME

Anthony Mordew

3. (b) Social Security Number

213-07-0488 A

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 8. (b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) May 14, 1877 6. (c) If alive, give age _____ years
 8. AGE: Years 68 Months 5 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Blacksmith
 11. Industry or business Bethlehem Steel Co.
 12. Name Jacob W. Mordew
 13. Birthplace Maryland
 14. Maiden name Rebecca A. Hartranft
 15. Birthplace Penna.

16. Informant Nephew: Newton Alder
 Address 410 Northbend Road, Baltimore, 29, Md.
 17. Burial Date thereof 10/25/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory McKendree Cem.
Black Horse, Harford Co., Md.
 Location WM. J. TICKNER & SONS
 18. Funeral director Balto., Md.
 Address

19. 10/24 19 45 A. W. Nadruil
 (Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 19 45, at 6A: M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 13, 1945 19 45, to Oct. 23, 19 45and that I last saw him alive on Oct. 22 19 45Immediate cause of death Cardio-Respir. FailureDue to HemiaDue to Arteriosclerotic C-v Dis.

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Chas. E. Corp. Md. M. D. or other _____Address Relay Sanitarium Date signed 10/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
 County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 5 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 1 month, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore-12
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 509 Radnor Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME
Sarah Morgan

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) January 23, 1870 6. (c) If alive, give age _____ years

8. AGE: Years 75 Months 8 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation Office work11. Industry or business Office12. Name Joseph A. Morgan13. Birthplace Hanover, Germany14. Maiden name Josephine Jackson15. Birthplace Baltimore, Maryland16. Informant Hospital recordsAddress Catonsville-28, Maryland

17. Funeral Date thereof 10/13/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium London ParkLocation Catonsville, Md.18. Funeral director William G. G. G.Address 1214 St. Paul St.19. Oct. 13 45 G. H. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1945 at 9:25a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 7, 1945 to October 12, 1945

and that I last saw her alive on October 12, 1945

Immediate cause of death Chronic myocarditis DURATION Indef.

Due to Generalized arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert E. Gardner, M.D. M. D. or other _____Address Catonsville-28, Md. Date signed 10/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Baltimore 20 (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 5 years
 Hospital, institution, or street address where death occurred:
1200 Shore Rd.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Baltimore
 City or town..... Baltimore 20 (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 1200 Shore Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Morsberger, Nellie V.

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... widow.
 6.(b) Name of husband or wife..... William Morsberger
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... March 24, 1890
 8. AGE: Years..... 75 Months..... 7 Days..... 0 If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business.....
 12. Name..... - Gardner
 13. Birthplace.....
 14. Maiden name..... - Hardesty
 15. Birthplace.....

16. Informant..... William Morsberger (son)
 Address..... 1200 Shore Rd.
 17. Burial Date thereof..... Oct 26, 1945
 (Burial, cremation, or removal? Which?) (month) (day) (year)
 Cemetery or crematory..... Loudon Park
 Location..... Baltimore, Md.
 18. Funeral director..... Harry H. Witzke
 Address..... 4101 Edmondson Ave Baltimore 28
 19. 10/25 19 45 Autopsy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 23 19 45 at 8 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 22 19 45 to Oct 23 19 45
 and that I last saw her alive on Oct 22 19 45

Immediate cause of death..... Pulmonary edema DURATION..... 2 hours
 Due to..... Hypertensive & Arteriosclerotic
Cardiovascular disease
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... Ray P. Bigham Jr M. D. or other
 Address..... Ridge Rd. Balt. 6, Md. Date signed..... Oct 24, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County BALTIMORE
 City or town REISTERSTOWN
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 DAYS
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CARRROLL
 City or town RURAL WESTMINSTER
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war _____

3. (a) FULL NAME

BLANCHE A. NELSON

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE WIDOW

6. (b) Name of husband or wife ROBERT L. NELSON

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) JANUARY 30, 1881

8. AGE: Years Months Days If less than one day
64 8 11 _____ hrs. _____ min.

9. Birthplace CARRROLL COUNTY, MD.
(Town, county, and state)10. Usual occupation NONE

11. Industry or business _____

12. Name RICHARD OWINGS13. Birthplace MD.14. Maiden name FRANCES E. SHIPLEY15. Birthplace MD.16. Informant MRS. C. C. EYLERAddress REISTERSTOWN, MD.17. BURIAL Date thereof 10/13/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory STONE CHAPELLocation WARFIELDSBURG, MD.19. Funeral director J. FRANCIS REESEAddress WESTMINSTER, MD.19. Oct. 12 19 45 MARY B. ELINE
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 11 19 45 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1-1- 19 43 to Oct 11 19 45
 and that I last saw her alive on Oct 11 19 45

Immediate cause of death Carcinomaof breastDue to MetastasisDue to CachexiaOther conditions L

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Date of op. _____

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James L. Saffell 10-12-45Address Reisterstown, Md M. D. or other _____Date signed 10/12/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09848

RECEIVED

OCT 16 1945

BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Hours
Hospital, institution, or street address where death occurred:
Veterans Hospital Fort Howard, Md.
How long in hospital or institution? 30 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1507 Mt. Moore Court
(If rural, give LOCATION)
W.W. 2
2.(a) If veteran, name war

3. (a) FULL NAME WILLIAM NICHOLSON
3. (b) Social Security Number Unknown

4. Sex MALE 5. Color or race COLORED 6. (a) Single, married, widowed, or divorced MARRIED
6. (b) Name of husband or wife Margaret Nicholson
6. (c) If alive, give age 23 years
7. Birth date of deceased (mo., day, yr.) June 30, 1919
8. AGE: Years 26 Months 3 Days 26 It less than one dayhrs.min.

9. Birthplace Ellerbe, N.C.
(Town, county, and state)
10. Usual occupation Mechanic
11. Industry or business Unknown
12. Name Thomas Nicholson
13. Birthplace Unknown
14. Maiden name
15. Birthplace

16. Informant Hospital Records Veterans Admin.
Address Fort Howard, Md.

17. Buried Date thereof 10-31-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory

Location Rockingham, N.C.
18. Funeral director Charles R. Rabin
Address 802 Madison Ave.

19. Oct 30, 1945 City Health Dept.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 19 45 at 4:42 p.m.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10/25/ 19 45 to 10/26 19 45
and that I last saw him in alive on October 26 19 45

Immediate cause of death.....
TOXIC HEPATITIS
ACIDOSIS
DURATION
4 Days
Unknown

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Ryan May Mc M. D. or other
Address Vets. Admin. Ft. Howard Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09849^P

OCT 31 1945
BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09850

38

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Rogers Forge (Balto. 12)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 23 months
 Hospital, institution, or street address where death occurred:
57 Murdock Road
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Baltimore
 City or town..... Rogers Forge (Balto. 12)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 57 Murdock Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

David Dennis Odell

3. (b) Social Security Number

none

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Baby

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... November 16, 1943

8. AGE: Years..... 1 Months..... 11 Days..... 6 If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation..... Baby11. Industry or business..... Baby12. Name..... Carlton E. Odell13. Birthplace..... Prompton, Penna.14. Maiden name..... Emma Lorene Wills15. Birthplace..... Jermyn, Penna.16. Informant..... Carlton E. OdellAddress..... 57 Murdock Road, Balto. 12, Md

Removal..... Oct. 23, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... A. F. Battenburg F. H.Location..... Jermyn, Penna.18. Funeral director..... John Buran's SonsAddress..... Towson, Maryland

19. Oct. 23 19 45 W. D. Odell Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 22 19 45 at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., 19....., 19.....

and that I last saw him..... 19.....

Immediate cause of death..... Stasis - typhoid lymphaticusDUE TO..... Accident - stumbled and fell giving acute stasis above - stasis typhoidus

DUE TO.....

Other conditions..... Previous similar attacks, less severe

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accidental fall Date of..... 10/22/45Where did injury occur?..... 57 Murdock Rd Balto. 12 (City or town) Baltimore (State) MdInjured at home, farm, industry, public place (where?)..... HomeMeans of injury..... Stumbled and fell Injured at work?..... no23. SIGNATURE..... Rollins G. Hudson MD DMEAddress..... Towson 4, Md Date signed..... 10/22/45

CERTIFICATE OF DEATH

File No.

DEPARTMENT OF HEALTH

FILE NO.

INCIDENT INFORMATION

RECEIVED
NOV 9 1945
BUREAU OF VITALS

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF INTERVIEW

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF INTERVIEW

DATE OF DEATH

DATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 870

CERTIFICATE OF DEATH

09851

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month 26 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 1 month 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford
 City or town..... Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Harry Webster Palmer

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married

6.(b) Name of husband or wife..... Lillian Hopkins

7. Birth date of deceased (mo., day, yr.)..... January 15, 1883 8.(c) If alive, give age..... 63 years

8. AGE: Years..... 62 Months..... 9 Days..... 3 If less than one day..... hrs. min.

9. Birthplace..... Aberdeen Harford Co., Md.
 (Town, county, and state)

10. Usual occupation..... laborer

11. Industry or business

12. Name..... Harry Webster Palmer13. Birthplace..... Pennsylvania14. Maiden name..... Louisa?15. Birthplace..... Pennsylvania16. Informant..... Records Spring Grove State HospitalAddress..... Catonsville, Md.17. Burial Date thereof..... Oct. 21/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Baker's CemeteryLocation..... Aberdeen, Md.18. Funeral director..... John JarrinAddress..... Aberdeen, Md.19. 10/19 19 45(Date rec'd by Registrar) N.C. Anderson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 18 19 45 at 6:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 19 45 to Oct. 18 19 45 and that I last saw him alive on Oct. 18 19 45

Immediate cause of death..... Tubercular pneumonia DURATION..... 2 days

Due to..... General debility caused by Parkinson's Syndrome over 1 yr.

Due to.....

Other conditions..... Dea culitus 2 wks.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Signature..... Robert E. Farnsworth M. D. or otherAddress..... Spring Grove Hospital, Catonsville, Md.Date signed..... Oct. 18, 1945

RECEIVED
OCT 22 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

09852

1. PLACE OF DEATH:

County Balto - 22
 City or town Turner Station
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 mos
 Hospital, institution, or street address where death occurred
204 Fleming Drive
 How long in hospital or institution? 5 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Penn County Philadelph
 City or town Philadelphia
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2534 Al 1915 St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Ethel Pearson

3. (b) Social Security Number

4. Sex female 5. Color or race C 6.(a) Single ☒ married, widowed, or divorced
 6.(b) Name of husband or wife Eugene Pearson
 6.(c) If alive, give age 47 years
 7. Birth date of deceased (mo., day, yr.) May 18, 1898
 8. AGE: Years 47 Months 8 Days 15 If less than one day
hrs. min.

9. Birthplace South Carolina
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Morris Posey13. Birthplace South Carolina14. Maiden name Mary Green15. Birthplace Annapolis, D.C.16. Informant Mrs. Etotel WilliamsAddress 204 Fleming Drive17. Burial Burial Date thereof 10-1-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Int. CalvaryLocation A. A. Co. &18. Funeral director Payner SandersAddress 1412 E. Preston St19. 1-2-45 auth
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1945 at 10:20P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 45 to Oct 45 and that I last saw him alive on 10-29-45 19Immediate cause of death Pneumonia DURATION 3 mosDue to Cachexia, inanitionDue to Hepatic cirrhosisOther conditions none

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur Pearson, M.D.Address 101 Breckenridge Dr M.D. or otherDate signed 10-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

Reg. Dist. No.

09853 P

1. PLACE OF DEATH

County Baltimore

City or town Balti Highlands
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balti

City or town Balti Highlands
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3018 Georgia Ave
(If rural give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

712-10-7799

3. (a) FULL NAME

Harry J. Polk.

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife.....

Theresa.

7. Birth date of deceased (mo., day, yr.)

Apr. 15 - 1913

8. AGE:

Years 32

Months 6

Days 11

It less than one day

.....hrs.min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

Welder

11. Industry or business

Bartlett & Hayward

12. Name

Frederick E. Polk.

13. Birthplace

Md

14. Maiden name

Mary E. Sayles

15. Birthplace

Md

16. Informant

Theresa Polk.

Address

3018 Georgia Ave Highlands

17.

Burial

Date thereof

10/30/88

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

London Pl.

Location

Balti

16. Funeral director

Wm Cook Inc

Address

212 St Paul St.

19. 10-29

19 45

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 26 -

19

45 at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 -

19 45

to Oct 26

19 45

and that I last saw him alive on Oct 26

19 45

Immediate cause of death

Pulmonary Tuberculosis

DURATION

2 year

Due to

Due to

Latent Tuberculosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Rue Schufeldt

M. D. or other

Address

23011 Annapolis

Date signed

10/28/88

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95d

CERTIFICATE OF DEATH

Reg. Diat. No. 09854.14

1. PLACE OF DEATH:

County Balto.City or town Rocky Point
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Rocky Point
(If outside city or town limits, write RURAL and give nearest town)Street No. Rocky Point
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George W. Porter

3. (b) Social Security Number

217-01-9524

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Stella E. Porter

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26th 1898

8. AGE: Years Months Days If less than one day

47 7 10 hrs. min.9. Birthplace Balto. Co. Md.
(Town, county, and state)10. Usual occupation Catcher11. Industry or business Eastern Rolling Mills12. Name Geo. H. Porter13. Birthplace Balto. Co. Md.14. Maiden name Anna Helderfer15. Birthplace Balto. City Md.16. Informant Mrs. G. W. PorterAddress Route 13 # 423 Balto. 2117. Burial Date thereof 10 10 45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sacred Heart of MaryLocation Balto. Co. Md.18. Funeral director Lassahn Funeral HomeAddress 7401 Belair Rd.19. Oct 9 45 J. J. Annally
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6th 19 45 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12 - 7 - 1943, to 10 - 6 - 1945and that I last saw him alive on 10 - 4 - 1945Immediate cause of death Chr. myocarditis

DURATION

2 yrs?Due to Pulmonary Emphysema

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. J. Dainoff M. D. or otherAddress 3218 Eastern Ave Date signed 10-8-45

RECEIVED

OCT 18 1945

BUREAU V 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-5

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. 608 W. Joppa Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Oliver Powers

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (d) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Sarah Ann

7. Birth date of

deceased (mo., day, yr.)

October - 6 1855

8. AGE:

90

Years

Months

Days

If less than one day

16

hrs.

min.

9. Birthplace

Clarksville Md.
(Town, county, and state)

10. Usual occupation

chain chaining

11. Industry or business

FATHER

12. Name

George Washington Powers

13. Birthplace

Maryland

MOTHER

14. Maiden name

Charity Beegman

15. Birthplace

Maryland

16. Informant

Address

Rev Cordell Powers
Towson Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Burial
Oct 23/45
(month) (day) (year)

Cemetery or crematory

St. Mary's Cemetery

Location

Oak Lane Cemetery

18. Funeral director

Address

John O. Mitchell Ford
1900 Fulton Place

19.

(Date rec'd by registrar)

10/24/4519. 45A. W. Nelson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 19 45 at 3:17 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19 45 to OCT 22 19 45
and that I last saw him alive on OCT 22 19 45

Immediate cause of death

Mitral insufficiency
secondary to atherosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Address

Towson 4, Md

M. D. or other

Date signed 10/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46a)

CERTIFICATE OF DEATH

Reg. Dist. No.

09856

P

1. PLACE OF DEATH:

County... BaltimoreCity or town... Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 87 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, MarylandHow long in hospital or institution? 87 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Washington County...City or town... Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 769 Girard Street, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war... WW-I

3. (a) FULL NAME

JOSEPH OTIS QUARLES

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>Negro</u>	<u>Married</u>

6. (b) Name of husband or wife... Vashtia Quarles6. (c) If alive, give age 46 years7. Birth date of deceased (mo., day, yr.) January 2, 1898

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>9</u>	<u>17</u>hrs.min.

9. Birthplace... Virginia
(Town, county, and state)10. Usual occupation... Porter

11. Industry or business

12. Name... Joseph Quarles13. Birthplace... Virginia14. Maiden name... Margaret Ragland15. Birthplace... Virginia16. Informant... Clinical Records, Vets. Adm. Fac.
Address Fort Howard, Md.17. Burial Date thereof... 10/24/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Arlington NationalLocation... Washington, D.C.18. Funeral director... Charles A. LawAddress 802 Madison Ave.19. 10-22 45 Am. Medical
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... October 20, 19 45, at 11:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 24, 19 45, to October 20, 19 45and that I last saw him alive on October 20, 19 45

Immediate cause of death...

Carcinoma of Esophagus

DURATION

Unknown

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. CullisonAddress Fort Howard, Md. Date signed 9-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Owings Mills
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs. 3 mos. 12 dys.
 Hospital, institution, or street address where death occurred:
Rosewood State Training School
 How long in hospital or institution? 3 yrs. 3 mos. 12 dys.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 206 S. Gilmar St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Susan Anne Racusin

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 5. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) September 2, 1940
 8. AGE: Years 5 Months 1 Days 12 It less than one day hrs. min.

9. Birthplace Baltimore City
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business None

MOTHER FATHER
 12. Name Nathan Racusin
 13. Birthplace Baltimore
 14. Maiden name Rosalie Shevitz
 15. Birthplace Brooklyn N.Y.

16. Informant Rosewood State Training School
 Address Owings Mills, Md. Records
 17. Burial Date thereof 10/15/45
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Rosevale
 Location Off Rd to Hamilton, Cal
 18. Funeral director Jack Lewis
 Address 1439 E. Balto St.

19. Oct 15 19 45
 (Date rec'd by registrar) Registrar M. W. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1945 at 11:05 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1942 to October 14, 1945
 and that I last saw her alive on October 14, 1945

Immediate cause of death DURATION
Lobar Pneumonia 1 dy.
 Due to
 Due to
 Other conditions Recurrent Bilateral Otitis Media 4 dys.
Recurrent Pyelitis 5 dys.
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Isabel H. McClinton M.D.
 Address Rosewood, Owings Mills, Md. Date signed Oct 14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Diat. No. 09858

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 Hrs. 20 Minutes
 Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
 How long in hospital or institution? 12 Hrs. 20 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County 00
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 911 West Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war VV-I

3. (a) FULL NAME

ROBERT JOHN RANDALL

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Frances Randall6. (c) If alive, give age 61 years

7. Birth date of

deceased (mo., day, yr.) 12-31-1880

8. AGE:

Years

Months

Days

If less than one day

64

9

12

.....hrs.min.

9. Birthplace West River, Maryland

(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER

12. Name Columbus Randall13. Birthplace Maryland

MOTHER

14. Maiden name Ellen Imes15. Birthplace Maryland18. Informant Clinical Records, Vets. Adm. Fac.Address Fort Howard, Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof 10/17/45
(month) (day) (year)Cemetery or crematory National CemeteryLocation West Street18. Funeral director Mrs. Charles D. HicksAddress 45 Northwest St Annapolis Md.

19.

(Date rec'd by registrar)

19

45

Registrar all

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1945 at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 12, 1945 to October 13, 1945
 and that I last saw him alive on October 13, 1945

Immediate cause of death

Hypertension & Coronary Arterio-
sclerosis

DURATION

10 Yrs.

Due to

Due to

Other conditions Cerebral Hemorrhage, old 3 Yrs.Hemiplegia, left & Cerebral Arterio-sclerosis (include pregnancy within 3 months of death)Unknown

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. M. BALTER, LT. COL., M.D. CLIN. DIR.Fort Howard, Md.Date signed 10-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09859

Reg. Dist. No. 9

1. PLACE OF DEATH:

County BaltimoreCity or town Towson, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 dayHospital, institution, or street address where death occurred
Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Balti
(If outside city or town limits, write RURAL and give nearest town)Street No. 300 E 25th St
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

William Pymel Redmond

3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Anna M. Redmond7. Birth date of deceased (mo., day, yr.) Jan 29 1887 6. (c) If alive, give age years8. AGE: Years 58 Months 8 Days 12 If less than one day
hrs. min.9. Birthplace Alphonia, Ind
(Town, county, and state)10. Usual occupation Salesman

11. Industry or business

12. Name Kiff Redmond13. Birthplace Maryland14. Maiden name Quam Clark15. Birthplace Maryland

Personal History Hospital Records

16. Informant Eudowood Sanatorium, Towson 4, Md.
Address17. Burial Date thereof Oct 13 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon ParkLocation 3801 Frederick Ave.18. Funeral director Harry W. W. W.Address 4101 E. Broadway Ave.19. Oct 11 19 45 A W Redmond
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 19 45 at 10:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 9 19 45 to Oct 10 19 45
and that I last saw him alive on Oct 10 19 45Immediate cause of death Pulmonary
1 BC

DURATION

11 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE William A. Bridges M. D. or otherAddress Towson 4 Maryland Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-2

CERTIFICATE OF DEATH

09860 30
Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town —
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 Mo..

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County —City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 118 Beechwood Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James H. Rider

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Caroline W. Rider6. (c) If alive, give age 86 years

7. Birth date of

deceased (mo., day, yr.) June 1, 1862

8. AGE:

Years

Months

Days

If less than one day

83

hrs. min.

9. Birthplace Brooklyn, N.Y.

(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

FATHER

12. Name

George Rider

13. Birthplace

Potter Hollow, N.Y.

MOTHER

14. Maiden name

Lucia Mulford

15. Birthplace

Rensselaerville, N.Y.

16. Informant

Mrs. Walter P. Backes

Address

118 N. Beechwood Ave.

17.

(Burial, cremation, or removal. Which?)

Date thereof Oct. 13, 1945
(month) (day) (year)

Cemetery or crematory

Trinity Episcopal

Location

Rensselaerville, N.Y.

18. Funeral director

Frederick A. Cole

Address

200 N. Lombard St.

19.

(Date rec'd by registrar)

10-10-45W. C. Anderson
Deputy Registrar

Address

Catonsville, Md.Date signed 10-10-45

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10th 19 45, at 9:55 A M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 10, 1944 to Oct. 10, 1945
and that I last saw him alive on Oct. 9 19 45

Immediate cause of death

Myocardial Infarction

DURATION

1 hr.

Due to

Rheumatic Cardio-Vascular Disease10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

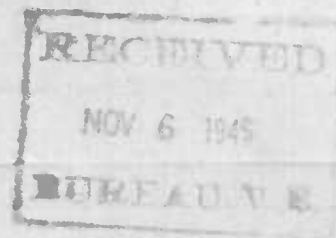
Injured at work?

23. SIGNATURE

William K. Gallagher M.D.

M. D. or other

Address Catonsville, Md.Date signed 10-10-45



Lv9 Drury Inc.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **09861**

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Hood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 615 Lyndhurst

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

August Rietdorf

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Married

6 (b) Name of husband or wife Anna M. Rietdorf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19, 1860

8. AGE: Years Months Days If less than one day
85 1 23 hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

12. Name Charles Rietdorf

13. Birthplace Luxemburg

14. Maiden Name Victoria Boedicker

15. Birthplace Berlin, Germany

16 (a) Informant Mr. James B. Upp

(b) Address 2821 Bauernwood Ave.

17 (a) Burial (b) Date thereof Oct. 15, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address North and Penna. Aves.

19 (a) Date of death Oct 15 1945 A. W. Hedrick
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6, 1945, to Oct 14, 1945, and that I last saw him alive on Oct 12, 1945.

Immediate cause of death

Cerebral Hemorrhage

Duration

2 days

Due to Cerebral Arteriosclerosis

2 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 715 Howard St Date signed 10/15

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

Dr. James Howell
715 Frederick Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Easel
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Easel
(If outside city or town limits, write RURAL and give nearest town)Street No. 403 Madeline Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Anna E Ripling

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Sammy

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 28 1849

8. AGE:

Years

Months

Days

If less than one day

96714hrs.min.

9. Birthplace

Baltimore MD
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

James C Coleman

13. Birthplace

Baltimore MD

MOTHER

14. Maiden name

Elizabeth Fields

15. Birthplace

MD

16. Informant

Sheldon Coleman

Address

403 Madeline Ave Easel MD

17.

(Burial, cremation, or removal. Which?)

Date thereof

10/16/45
(month) (day) (year)

Cemetery or crematory

Moulton Park

Location

Baltimore MD

18. Funeral director

William G. G. Inc

Address

Baltimore MD

19.

Oct 13 1945
(Date rec'd by registrar)A. H. Hedrick
per A. E. E.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 19 45 at 10:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 5 19 45 to Oct 12 19 45
and that I last saw him alive on Oct 12 19 45

Immediate cause of death

Bronchitis - Pneumonia

DURATION

5 days

Due to

Due to

Other conditions

Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Armand M. Hummel

M. D. or other

Address

Easel MDDate signed 10/13/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No. 49863 9 49

1. PLACE OF DEATH:

County..... Balto.
 City or town..... Pond Rd. Middle River.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 8 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Frances (Dembeck) Rochowski

3. (b) Social Security Number

4. Sex..... female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... married

6. (b) Name of husband or wife..... Michael7. Birth date of deceased (mo., day, yr.)..... 3/12/21

8. AGE: Years..... 74 Months..... 7 Days..... 7 less than one day..... hrs...... min.

9. Birthplace..... Poland.
(Town, county, and state)10. Usual occupation..... House wife

11. Industry or business

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant..... Wm. GloverAddress..... Pond Rd. Middle River17. Burial Date thereof..... 10-23-45
(Burial, cremation, or removal, Which? (month) (day) (year))Cemetery or crematory..... St. StanislausLocation..... Dundalk Ave. Balto Md.18. Funeral director..... James BrudemikeAddress..... 1407 Eastern Ave Rd.19. 10-22-45 19..... Clifford
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Balto
 City or town..... Middle River
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Pond Rd.
 (If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 19..... 19..... 45..... at..... 6 P..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... July 1..... 19..... 45..... to..... Oct 19..... 19..... 45.....
 and that I last saw him alive on..... Oct 19..... 19..... 45.....

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

Sudden

Due to..... arteriosclerotic Cardiac
vascular disease

Due to..... Senility

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Geo M. Brummendick
M. D. or otherAddress..... Balto Md Date signed..... 10/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Balto.
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, institution, or street address where death occurred:
Ship yard.
How long in hospital or institution? 4 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Balto.
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1210 N. Eden St.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME

Tom Rosser

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Married

7. Birth date of deceased (mo., day, yr.) 1907 8.(c) If alive, give age years

8. AGE: Years 38 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Crane Hook (Town, county, and state)

10. Usual occupation B. D. Co. Ship yard

11. Industry or business B. D. Co. Ship yard

12. Name Tom Rosser

13. Birthplace N.C.

14. Maiden name Martha Williams

15. Birthplace N.C.

16. Informant Dr. Gill

Address (Dr. Gill)

17. Burial Date thereof 11-2-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Odell

Location Shore Hill N.C.

18. Funeral director William A. Jackson

Address 914 Penn Ave Balto

19. 10730745 J. M. Learmore
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Oct 29 1945 at 4:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1945, to 19
and that I last saw him alive on 19

Immediate cause of death Multiple fracture of skull (crushed)
Due to fall
Due to fall

DURATION Immediate

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10/29/45

Where did injury occur Sparrows Pt. Balto. Ind.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Industry

Means of Injury Fall Injured at work? yes

23. SIGNATURE J. M. Learmore M.D. or other Deputy Medical Examiner
Address Baltimore, Md. Date signed 10/30/45

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

NO. 1

FILE NO. 100-100000

RECEIVED
NOV 7 1945
BUREAU OF V.I.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482

CERTIFICATE OF DEATH

09865

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
 City or town Towson Md. 10 Md. Ave
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto
 City or town Towson
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 10 Md. Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clara Luella Royston

3. (b) Social Security Number

4. Sex

Female

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

February 21, 1875

6. (c) If alive, give age..... Years

8. AGE:

Years

Months

Days

If less than one day

70812

.....hrs.min.

9. Birthplace

Phoenix Balto. Co. Md.
(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

MOTHER FATHER

12. Name

J. Marion Royston

13. Birthplace

Balto Co. Md.

14. Maiden name

Jessie A. Price

15. Birthplace

Balto. Co. Md.

16. Informant

Horace Royston

Address

10 Md. Ave, Towson Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

10 6 45
(month) (day) (year)

Cemetery or crematory

Gossops Methodist

Location

Sparks, Md.

18. Funeral director

Tandon M. Brooks

Address

Sparks, Md.

19.

(Date rec'd by registrar)

15

Oct 5 1945
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 3

19

45

at

9 P.

M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 11 1945 to Oct 2 1945
 and that I last saw him alive on Oct 2 1945

Immediate cause of death

Carcinoma (Uterus)

DURATION

2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Amputation
Carcinoma uteri

Date of op.

6/23/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John L. Green

M. D. or other

Address

Bowen - 4 - Md.

Date signed

10/4/45

RECEIVED
NOV 5 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No.

CERTIFICATE OF DEATH

09866

33^P

1. PLACE OF DEATH:

(a) County Baltimore
 (b) City or town Reisterstown
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution: Box 11 Pleasant
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 11 1/2 mos.
 (e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County _____
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1729 E. Baltimore Street
 (If rural give location)
 (e) If foreign born, how long in U. S. A. 30 years

3 (a) FULL NAME

Hyman Rubin

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Sarah Rubin

6. (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.)

October 15, 1874

8. AGE:

Years 71

Months

Days 11

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER
MOTHER

12. Name

Samuel Rubin

13. Birthplace

Russia

14. Maiden Name

Manion ?

15. Birthplace

Russia

16 (a) Informant

Sarah Rubin

(b) Address

1729 East Baltimore St.

17 (a)

Burial

(b) Date thereof

10-26-45

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Rosedale

Location

Baltimore Co., Md.

18 (a) Funeral director

Face Heine Inc

(b) Address

1739 E. Balt. St.

19 (a)

10/26/45

(b)

R. W. Friedrich

Registrar

MEDICAL CERTIFICATION

20. Date of death October 26, 1945, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9, 1944, to Oct 26, 1945, and that I last saw him alive on Oct. 26, 1945.

Immediate cause of death

Myocardial Failure

Due to Congestive Heart Failure

Due to Pulmonary Tuberculosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

18 mos. 6 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)
 (e) Means of injury

23. Signature

Albert F. Shier M.D.

M. D. or other

Address

Reisterstown, Md.

Date signed

Oct. 26, 1945

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09867 33
★ Reg. Dist. No.

1. PLACE OF DEATH:

County Balto.
City or town Reisterstown, Ind.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 da.
Hospital, institution, or street address where death occurred:
In shed on John Shroyers Farm
How long in hospital or institution? on Westminster Pike

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md. County Balto City
City or town Reisterstown, Ind.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1525 W. 36th St. Hamden - Balto.
(If rural, give LOCATION) Ind.
(a) If veteran, name war

3. (a) FULL NAME

Wm E. Sakers

3. (b) Social Security Number

219-07-5990

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Lilla Sakers
7. Birth date of deceased (mo., day, yr.) May 29 1891
6. (c) If alive, give age 54 years
8. AGE: Years 54 Months 4 Days 8 If less than one day hrs. min.
9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual occupation -
11. Industry or business -
FATHER 12. Name Unknown
13. Birthplace -
MOTHER 14. Maiden name Lilla -
15. Birthplace -

16. Informant Mrs Lilla Sakers
Address 1525 W. 36th St Baltimore Md.
17. BURIAL Date thereof 10-7-45
(Burial, cremation, or removal) (Which?) (month) (day) (year)
Cemetery or crematory Baltimore City (Ex)
Location Baltimore City
18. Funeral director Burial Funeral Home
Address 3631 Falls Road Balto Md.

19. Oct 7 45 Dean B. Dine
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 19 45 at 9 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Oct 7 19 45
and that I last saw him live on Oct 7 19 45
Immediate cause of death Coronary Occlusion
DURATION Between 10 & 12 hrs
Due to -
Due to -
Other conditions -
(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. -
Autopsy results -
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of -
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -
Means of injury - Injured at work? -
23. SIGNATURE D. D. Caples, M.D. M. D. or other -
Address Reisterstown, Ind. Date signed 10-7-45

is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 10 1945
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(942)

CERTIFICATE OF DEATH

09868

Reg. Dist. No.

1. PLACE OF DEATH:

County..... *Baltimore*City or town..... *Haltershe*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5716 Second Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Baltimore*City or town..... *Haltershe*
(If outside city or town limits, write RURAL and give nearest town)Street No. *5716 Second Ave*
(If rural, give LOCATION)

2.(c) If veteran, name war

3. (a) FULL NAME

Mary A. Scheufele

3. (b) Social Security Number

4. Sex

Female

5. Color of face

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Albert F. Scheufele

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Mar. 5, 1895

8. AGE:

Years

Months

Days

If less than one day

*50**8**1*

hrs.

min.

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Machine operating & small co

12. Name

Joseph F. Sawyer

13. Birthplace

Baltimore, Maryland

14. Maiden name

Agnes Owens

15. Birthplace

Baltimore, Md

16. Informant

Albert F. Scheufele

Address

5716 Second Ave Haltershe

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Oct. 9, 1945
(month) (day) (year)

Cemetery or crematory

Holy Cross Ch

Location

A. G. I. Co. West

18. Funeral director

Thyrum & Fleming

Address

1476 Regt St. Baltimore Md

19.

10-8-45
(Date rec'd by registrar)

19.

*85**Am. School*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Oct. 6*..... 19 *45*, at *11* *30* *A*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1..... 19 *45* to *Oct. 6*..... 19 *45*and that I last saw him..... alive on *Oct 6*..... 19 *45*

Immediate cause of death

Cervical thrombosis

DURATION

Due to.....

Due to.....

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

*Myoma of uterus*Date of op. *9/22/45*

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Alphonse H. G. Smith

M. D. or other

Address *4209 2nd Ave* Date signed *10/8/45*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

09869

Reg. Dist. No. 441

1. PLACE OF DEATH:

County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred: _____
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Baltimore
 City or town Lipsch Road & Wise Ave
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Soundale 22nd
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth Scott

3. (b) Social Security Number

4. Sex Female5. Color or race Colored6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE:	Years	Months	Days	If less than one day
<u>70</u>				
			hrs.	min.

9. Birthplace N.A.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Menay Cole13. Birthplace Ba.14. Maiden name Martha Wright15. Birthplace Ba.16. Informant Fredrick ColeAddress 11 Cottage Ave.17. Burial Date thereof Nov 4, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mrs. Calrang Cem.Location A. A. County Md.18. Funeral director Mrs. Robert A. Elliott & SonAddress 1129 N. Caroline St.19. 11/2 19 45 A. W. Hedrick
(Date rec'd by registrar.) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29th 19 45, at 6 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased August 4, 1945 to Oct 29th 1945and that I last saw him alive on October 29 - 45Immediate cause of death Pneumo-pneumoniaDURATION 2 wks.

Due to _____

Due to Carcinoma of stomach

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations none

Antemortem results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. H. Thomas M.D.Address Turner's StaDate signed 10/31/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

109

CERTIFICATE OF DEATH

 09870 38
 Reg. Dist. No.

1. PLACE OF DEATH:

 County Baltimore
 City or town Providence (rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hart Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State Maryland County Baltimore
 City or town Providence (rural)
 (If outside city or town limits, write RURAL and give nearest town)

 Street No. Hart Road
 (If rural, give LOCATION)

 Street No. Hart Road
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Shirley Anne Scovens

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

 8. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) September 29, 1943

8. AGE:

 Years 2 Months — Days 18 If less than one day
 hrs. min.

 9. Birthplace Providence, Balto. Co., Md.
 (Town, county, and state)

10. Usual occupation

Babe

11. Industry or business

Babe12. Name Benjamin Scovens13. Birthplace Providence, Md.14. Maiden name Lucille Braxton15. Birthplace Lutherville, Md.16. Informant Benjamin ScovensAddress Providence, Md.17. Burial Date thereof Oct 18, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pleasant Rest CemeteryLocation Towson, Md.18. Funeral director John Burns' SonsAddress Towson, Md.19. Oct. 18, 1945 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17, 1945, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him/her on same 19.....Immediate cause of death Pneumonia, lobarright lungDURATION 4 days

Due to.....

Due to.....

Other conditions Congenital brain defectundveloped (harvested, no inspection)

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Rolling B. Hudson MDAddress Towson, Md. Date signed 10/17/45

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
NOV 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 457

CERTIFICATE OF DEATH

09871

P

Reg. Dist. No.

1. PLACE OF DEATH:

County..... **Baltimore**
 City or town..... **Fort Howard**
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **28 Days**
 Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution?..... **28 Days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County.....

City or town..... **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... **2733 E. Monument St.**
 (If rural, give LOCATION)

2.(a) If veteran, name war..... **WW**

3. (a) FULL NAME

CHRISTOPHER J. SEIDEL

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

Male**White****Divorced**

6.(b) Name of husband or wife..... **Divorced**

7. Birth date of deceased (mo., day, yr.)..... **1-6-1899**
 6.(c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day.....
46 9 20 hrs. min.

9. Birthplace..... **Overlea, Maryland**
 (Town, county, and state)

10. Usual occupation..... **Unemployed**

11. Industry or business

12. Name..... **John J. Seidel**

13. Birthplace..... **Germany**

14. Maiden name..... **Ella Richie**

15. Birthplace..... **Ireland**

16. Informant..... **Clinical Records, Vets. Adm. Fac.**

Address..... **Fort Howard, Maryland**

17. **Burial** Date thereof..... **10/30/1945**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... **Lutheran Bur.**

Location..... **B. Blair Bldg. Baltimore**

18. Funeral director..... **Oder Funeral Home Inc.**

Address..... **4644 York Rd.**

19. **10/29/45** Registrar.....
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **October 26, 1945** at **7:05 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 28, 1945 to **October 26, 1945**
 and that I last saw him alive on **October 26, 1945**

Immediate cause of death.....
Carcinoma of the Naso-Pharynx

DURATION

Unknown

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

SIGNATURE..... **A. M. BALTER, LT. COL., M.C.P. CTN. DIR.**

Address..... **Fort Howard, Md.** Date signed..... **10-28-45**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BALTIMORECity or town CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

OPITZ HOME

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State MD County BALTIMORECity or town BALTIMORE
(If outside city or town limits, write RURAL and give nearest town)Street No. 734 WARWICK ROAD
(If rural, give LOCATION)2.(a) If veteran, name war NONE

3. (a) FULL NAME

CATHERINE THERESA SHANAHAN

3. (b) Social Security Number

NONE4. Sex FEMALE5. Color or race WHITE6. (a) Single, married, widowed, or divorced WIDOW6. (b) Name of husband or wife EDWARD A.

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) JANUARY 30-18768. AGE: Years 69 Months 8 Days 15 It less than one day _____ hrs. _____ min.9. Birthplace BALTIMORE MD
(Town, county, and state)10. Usual occupation NONE11. Industry or business NONE12. Name BERNARD M. SUICK13. Birthplace IRELAND14. Maiden name CATHERINE T. FITZPATRICK15. Birthplace IRELAND16. Informant ARTHUR B. SHANAHANAddress 5751 OREGON AVE. ARBUTUS17. Burial Date thereof OCT 18-1945
(Burial, cremation, or removal, which) (month) (day) (year)Cemetery or crematory NEW CATHEDRALLocation CHURCH OF B. M. WALTERS18. Funeral director PRATT STRUCKERAddress 1001 N. CHARLES ST.19. OCT 17 1945 (Date rec'd by registrar)Registrar ADW HEDRICK

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 15 19 45 nt. 29 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 26 19 45 to Oct 15 19 45and that I last saw him alive on Oct 14 19 45Immediate cause of death Pulmonary edemaDue to Cerebral accidentDue to ArteriosclerosisOther conditions Secondary Angina

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James E. LohmeyerAddress 721 Melrose Ave. BklynDate signed 10/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 945

CERTIFICATE OF DEATH

Reg. Diat. No. 33.

1. PLACE OF DEATH:

County BaltoCity or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 17 Main St.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Margie Lillian Sherman

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

widowed6.(b) Name of husband or wife Dr. J. H. Sherman7. Birth date of deceased (mo., day, yr.) Aug. 1, 1888

8.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

57213

_____ hrs.

_____ min.

9. Birthplace Carroll Co.

(Town, county, and state)

10. Usual occupation School teacher

11. Industry or business

12. Name Arthur Hill13. Birthplace Carroll Co.14. Maiden name Catherine M. Lockdale15. Birthplace Carroll Co.16. Informant Herbert HillAddress Reisterstown, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Oct. 17, 1945

(month) (day) (year)

Cemetery or crematory All SaintsLocation Reisterstown, Md18. Funeral director J. B. Eline & SonsAddress Reisterstown, Md.19. Oct. 17 19 45 Mary B. Eline.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1945 at 4:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 14 1945 to 19and that I last saw him not seen alive 19

Immediate cause of death _____

Carmory & occlusion

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE D. D. Caples, M.D. M. D. or otherAddress Reisterstown, Md. Date signed 10-16-45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

A. W. HUNTER, M.D., M.P.H.

PLACE OF DEATH

MEDICAL CERTIFICATION

RECEIVED
OCT 22 1965
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

09874

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Batts.
City or town Tinsomon Ind.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 29 yrs. - 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Batts.
City or town Tinsomon Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. York Rd. - Ind.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Annie May Simpson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Harry E. Simpson

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Aug. 28 / 1877

8. AGE: Years 68 Months 1 Days 2 If less than one day
hrs. min.

9. Birthplace New Perke. Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Wm. J. Enfield

13. Birthplace Pa.

14. Maiden name Mattha Brooks

15. Birthplace Pa.

16. Informant Harry E. Simpson
Address Tinsomon Ind.

17. Burial Date thereof Oct 3 / 45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory West Liberty

Location Tinsomon Ind.

18. Funeral director Howard A. Gill

Address 18 W. Penna Ave. Tinsomon.

19. Oct. 2 19 45 Wilmer C. Ensor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 19 45 at 4:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 45 to 10/1 19 45
and that I last saw her alive on 9/30 19 45

Immediate cause of death Carcinoma (Gastric) DURATION 6 mo.

Due to

Due to

Other conditions Myocarditis 3 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Wilmer C. Ensor M.D. M. D. or other

Address Cockeysville Md. Date signed 10/1/45

MARGIN RESERVED FOR BINDING

VS A151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 3 1945
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 34

1. PLACE OF DEATH: Baltimore
 County.....
 City or town..... near Hoffmannville Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 25 years
 Hospital, institution, or street address where death occurred.....
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Baltimore
 City or town..... near Hoffmannville Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Bertha May Smith

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married
 8. (b) Name of husband or wife..... Clarence L. Smith
 6. (c) If alive, give age..... 55 years
 7. Birth date of deceased (mo., day, yr.)..... Nov 30, 1892
 8. AGE: Years..... 52 Months..... 10 Days..... 29 If less than one day..... hrs. min.

9. Birthplace..... Maryland
 (Town, county, and state)
 10. Usual occupation..... House wife
 11. Industry or business.....

12. Name..... A. Harry Myers
 13. Birthplace..... Maryland
 14. Maiden name..... Sarah E. Folsom
 15. Birthplace..... Maryland

16. Informant..... Clarence L. Smith
 Address..... Millers Md
 17. Burial Date thereof..... 10-31-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cemetery
 Location..... St. Peter Church Baltimore
 18. Funeral director..... Isabel Wink's Sons
 Address..... Manchester Md

19. Oct 30 19 45 April E. Folsom
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct. 29 19 45 at 2 45 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 20 19 45 to Oct 29 19 45
 and that I last saw him alive on Oct. 27 19 45

Immediate cause of death..... Carcinoma of the body of the uterus
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE..... G. M. France M. D. or other
 Address..... Harleton, Ind. Date signed..... 10/29/45

RECEIVED
NOV 7 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09876

P

Reg. Dist. No.

1. PLACE OF DEATH

County BALTIMORECity or town LANSDOWNE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

38 SECOND AVENUEHow long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORECity or town LANSDOWNE
(If outside city or town limits, write RURAL and give nearest town)Street No. 38 SECOND AVENUE
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

ELEANOR ELIZABETH SMITH

3. (b) Social Security Number

NONE

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED6.(b) Name of husband or wife LOUIS V. SMITH

7. Birth date of deceased (mo., day, yr.)

JAN. 7- 18986.(c) If alive, give age 41 years

8. AGE:

Years

Months

Days

If less than one day

47918

hrs.

min.

9. Birthplace

BALTIMORE MARYLAND
(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

HOME

MOTHER FATHER

12. Name

HARRY R. WADE

13. Birthplace

BALTIMORE CO.

14. Maiden name

CAROLINE M. DORGE

15. Birthplace

BALTIMORE, CO.

16. Informant

LOUIS VERNON SMITH

Address

38 SECOND AVENUE

17.

BURIAL

Date thereof

OCT. 29-45
(month) (day) (year)

Cemetery or crematory

LOUDON PARK CEMETERY

Location

FREDERICK AVENUE

18. Funeral director

C. RAYMOND KAUFMAN

Address

1076 KEEPS AVENUE

19.

1896-45

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

OCT. 2519 45 at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-12-45

19

to 10-25-45

19

and that I last saw her alive on 10-25-45

19

Immediate cause of death

Adenocarcinoma

DURATION

2 cm x18 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

P. R. BANGLE

M. D. or other

Address

642 Wash. Blvd

Date signed

10-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

09878

CERTIFICATE OF DEATH



Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Balto.
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Westminster Road
(If rural, give LOCATION)
2. (a) If veteran, name war. None

3. (a) FULL NAME

Maria M. Smith

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 18, 1855

8. AGE: Years 90 Months 5 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace New Jersey
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name John Smith

13. Birthplace Ireland

MOTHER 14. Maiden name Winifred Egan

15. Birthplace Ireland

16. Informant Miss Winifred Smith

Address Reisterstown, Md.

17. Burial Date thereof Oct. 6, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Balto. Co.

18. Funeral director J.F. Eline & Sons

Address Reisterstown, Md.

19. 10-5 19 45 Army B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3-1945 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-1940 to 10-3-1945 and that I last saw her alive on 10/2/45

Immediate cause of death Result of chronic nephritis
Due to Diabetes
Due to Arteriosclerosis
Accidental fall, stairs
Other conditions Fractured hip -
vomiting & diarrhea terminal
(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of May 1945

Where did injury occur? Reisterstown Baltimore Maryland
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At her home

Means of injury Accidental fall Injured at work? _____

23. SIGNATURE Dr. J. F. Eline M. D. or other _____

Address Reisterstown, Md. Date signed 10/3/45

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 9 1945
BUREAU OF
POSTAL SERVICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1172

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 Day
 Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
 How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Hurlock
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Eastern Shore
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

WILLIAM SMITH

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced
 6.(b) Name of husband or wife
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) 12-15-94
 8. AGE: Years 50 Months 10 Days 10 If less than one day
 hrs. min.

9. Birthplace Delaware
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name
 13. Birthplace
 14. Maiden name
 15. Birthplace

16. Informant Clinical Records, Vets. Adm. Fac.
 Address Fort Howard, Md.

17. Burial Date thereof 10-31-45
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Baltimore Nat.

Location Balto. City

18. Funeral director Charles J. ...

Address 802 Madison Ave.

19. 1930 19 45 Charles J. ...
 Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 19 45 at 2:55 P.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 24, 19 45 to October 25, 19 45
 and that I last saw him alive on October 25, 19 45

Immediate cause of death
Generalized Peritonitis DURATION 48 Hrs.

Due to Perforated Gastric Ulcer 6 Mos.
plus

Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. B. Davis, M.D.
 and John M. Davis, M.D.
 Address Delmar, Del. Date signed 10/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County.....Balto
 City or town.....Bethesda River
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Snyder

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Elvina

7. Birth date of

deceased (mo., day, yr.)

1877

8. AGE:

74

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Penna.
(Town, county and state)

10. Usual occupation

Contractor

11. Industry or business

Henry Snyder

12. Name

13. Birthplace

Penna.

14. Maiden name

Margaret Bernwardt

15. Birthplace

Penna.

16. Informant

Elvina SnyderAddress Bethesda BeachBurial

(Burial, cremation, or removal. Which?)

Date thereof 10/31/45
(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

Balto & Co

18. Funeral director

James J. Burgen

Address

1407 Eastern Ave Rd19. Oct. 31 - 19 45

(Date rec'd by registrar)

Wm. H. Connolly

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md County.....BaltoCity or town.....Bethesda River

(If outside city or town limits, write RURAL and give nearest town)

Street No.....Cedar Beach Md

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Oct 28.....19 45, at 5:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 21.....19 45, to Oct 28.....19 45and that I last saw him alive on Oct 28.....19 45

Immediate cause of death

Bronchial pneumonia

DURATION

2 days

Due to

Cerebral apoplexy

1 wk

Due to

arterio-sclerotic-Cardiovascular disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

Wm. H. Connolly

M. D. or other

Address.....Balto & Md..... Date signed.....10/29/45

RECEIVED
NOV 3 1945
BUREAU Y.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3A

1. PLACE OF DEATH:

County BaltimoreCity or town Armonium
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Armonium
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed or divorced

Married

6. (b) Name of husband or wife

Mary Elizabeth

7. Birth date of deceased (mo., day, yr.)

March 30, 1870

6. (c) If alive, give age _____ years

8. AGE:

Years 75Months 6Days 11

If less than one day

_____ hrs. _____ min.

9. Birthplace

Hallston MD
(Town, county, and state)

10. Usual occupation

Appraiser Orphan's Court

11. Industry or business

Baltimore MD

MOTHER

FATHER

12. Name

James Augustus Spier

13. Birthplace

Hallston MD

14. Maiden name

Elizabeth S. Lee

15. Birthplace

Hallston MD

16. Informant

Garbus Spier

Address

Armonium MD

17. Burial, cremation, or removal. Which?

Burial

Date thereof

10/17/45
(month) (day) (year)

Cemetery or crematory

Grundy's ME

Location

Hallston MD

18. Funeral director

William Cook Inc

Address

1214 St Paul St19. 10/16

(Date rec'd by registrar)

1945A. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 19 45 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 26, 43 to Oct 14 19 45and that I last saw him alive on Oct 14 19 45

Immediate cause of death

Apoplexy

Due to

Arterio-sclerosis

Due to

& hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James Augustus SpierAddress Armonium - MDDate signed 10/17/45

M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

Reg. Dist. No. 09881 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mt. Wilson, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 4 mos., 17 days
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
 How long in hospital or institution 0 yrs., 4 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town 4014 Falls Rd., Balto., Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4014 Falls Rd.
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Charles H. Spreckelmeyer

3. (b) Social Security Number

220-24-5065

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ethel Spreckelmeyer6. (c) If alive, give age 52 years7. Birth date of deceased (mo., day, yr.) March 18, 1885

8. AGE: Years 60 Months 7 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Machinist

11. Industry or business

12. Name George A. Spreckelmeyer13. Birthplace Baltimore, Maryland14. Maiden name Catherine McCourt15. Birthplace Baltimore, Maryland16. Informant Charles H. SpreckelmeyerAddress Balto., Md.-4014 Falls Rd.17. Burial Date thereof Oct. 25, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New Cathedral CemeteryLocation 4300 Old Frederick Rd., Balto., Md.16. Funeral director Burgee Funeral HomeAddress 3631 Falls. Rd., Balto., Md.19. Oct. 21, 1945 Earl F. Webster
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21, 1945 at 8:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Octo June 4, 1945 to October 21 1945and that I last saw him alive on October 21, 1945Immediate cause of death Pulmonary TuberculosisDURATION 3 Yrs., 1 Mo.Due to Tubercle Bacilli

Due to _____

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operationAutopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stewart S. Shaffer M.D.Address Mt. Wilson, Md. Date signed 10/22/45

RECEIVED
OCT 24 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09882

P

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? D.O.A.

Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Md.

How long in hospital or institution? D. O. A.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 919 Myrtle Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME

EDWARD R. STEPHENS

3. (b) Social Security Number

4. Sex Male

5. Color or race
Negro

6.(a) Single, married, widowed, or divorced
Married

6.(b) Name of husband or wife Pearl Stephens

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) August 7, 1889

8. AGE: 56 Years 2 Months 4 Days
if less than one day
.....hrs.min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Porter

11. Industry or business ?

12. Name Alec Stephens

13. Birthplace Virginia

14. Maiden name Matilda Petters

15. Birthplace Virginia

16. Informant Clinical Records,

Address Vet. Adminis. Fort Howard, Md.

17. Burial

Date thereof 10-1-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Baltimore, Md.

Location

18. Funeral director Charles R. Law

Address 802 Madison, Balto., Md.

19. 10/30 45

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1945, at D.O.A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to19.....

and that I last saw himalive on19.....

Immediate cause of death.....

SYPHILITIC HEART DISEASE

DURATION

Unknown

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

09883

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baeto. Co.City or town Catonsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BAETONCity or town Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 10116
(If rural, give LOCATION)2.(a) If veteran, name war World War I

3. (a) FULL NAME

Susan B. Tuel

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed8. (b) Name of husband or wife Peter Tuel7. Birth date of deceased (mo., day, yr.) Jan 14 1868 8. (c) If alive, give age 77 years8. AGE: Year 77 Months 0 Days 0 If less than one day 0 hrs. 0 min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation domestic11. Industry or business House wife12. Name Susan B. Tuel13. Birthplace Maryland14. Maiden name Mary Frances Johnson15. Birthplace Maryland16. Informant Chief TuelAddress 114 Mellon Ave17. Burial Date thereof 10/16/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Studen ParkLocation Baeto Co.18. Funeral director Edw. Mrs. NabbAddress Catonsville Md.19. 10/16 19 45 N.C. Underage

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 19 45 at 11:50 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14 19 45 to Oct 13 19 45 and that I last saw her alive on Oct 13 19 45Immediate cause of death Chronic myocarditisDue to Graves' diseaseDue to Graves' diseaseOther conditions 30 years

(Include pregnancy within 3 months of death)

Major findings of operations noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of noneWhere did injury occur? none (City or town) (County) (State)Injured at home, farm, industry, public place (where?) noneMeans of injury none Injured at work? none23. SIGNATURE J. C. UnderageAddress Catonsville M. D. or other 10/15Date signed 10/15

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

MEDICAL CERTIFICATION

RECEIVED
OCT 22 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (312)

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.
 City or town Victory Villa
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 mo.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balto.
 City or town Victory Villa
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5 Yawmeter Rd.
 (If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

MARY TYLES.

3. (b) Social Security Number

4. Sex 7. Color or race 6. (a) Single, married, widowed, or divorced

F.N.married

6. (b) Name of husband or wife

Charles Tylo6. (c) If alive, give age 72 years

7. Birth date of

deceased (mo., day, yr.)

Jan. 26 - 1879

8. AGE:

Years

Months

Days

If less than one day

6694

hrs. min.

9. Birthplace

N. Y. City
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John Ptasek

13. Birthplace

Bohemia

MOTHER

14. Maiden name

Josephine ?

15. Birthplace

Bohemia

16. Informant

Charles Tylo

Address

Marydel, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 1 - 1945
(month) (day) (year)

Cemetery or crematory

Oak Hill

Location

Horners Lane

18. Funeral director

John B. Connolly

Address

Beth, Md.

19. Oct. 31

(Date rec'd by registrar)

19 45John B. Connolly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 19 45 at 1:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 7 19 45 to Oct 23 19 45and that I last saw him alive on Oct 23 19 45

Immediate cause of death

Cerebral haemorrhage

DURATION

1 hr.

Due to

Hypertensive cardiac vascular disease10 yrs

Due to

Chronic glomerulonephritis?

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

W. C. Fuller M.D.

M. D. or other

Address Ridge Rd, Baltimore-6 Date signed 10/30/45md.

RECEIVED

NOV 1 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Reg. Dist. No.

198854/0

1. PLACE OF DEATH:

County... BaltimoreCity or town... White Marsh
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... BaltimoreCity or town... White Marsh
(If outside city or town limits, write RURAL and give nearest town)Street No. Ebenzer Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

THOMAS A VINCENT

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife... Helen M. Vincent

7. Birth date of

deceased (mo., day, yr.)

March 24th 1872

8. AGE:

Years

Months

Days

If less than one day

73616

hrs.

min.

9. Birthplace

Baltimore Co. Maryland
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

Richard Vincent

13. Birthplace

England

MOTHER

14. Maiden name

Ann E. Merritt

15. Birthplace

Anne Arundel Co. Md.

16. Informant

Mrs. Thomas A. Vincent

Address

Ebenzer Road White Marsh Md17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct 11th 1945
(month) (day) (year)

Cemetery or crematorium

Ebenzer Methodist

Location

Chase, Ind.

18. Funeral director

Lessahm Funeral Home

Address

7401 Belair Road19. 10/10/45

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 91945

at

3:20 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 51944

to

Oct 91945

and that I last saw him

alive on

Oct 61945

Immediate cause of death

Asystole

DURATION

Due to

Arteriosclerotic cerebral disease

Due to

Other conditions

Gen'l arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Guller MD

M. D. or other

Address

Ridge Road, Baer 6

Date signed

Oct 9/45

RECEIVED

OCT 23 1945

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No. *XX*

1. PLACE OF DEATH:
County *Baltimore*
City or town *Sparrows Point*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *20 years*
Hospital, institution, or street address where death occurred:
2106 Oak Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State *MD* County *#1*
City or town *Sparrows Point*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *2106*
(If rural, give LOCATION)
2. (a) If veteran, name war *None*

3. (a) FULL NAME
Mary Evelyn Walter

3. (b) Social Security Number
None

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*
6. (b) Name of husband or wife *Robert Claude Walter*
7. Birth date of deceased (mo., day, yr.) *Nov. 29, 1878* 6. (c) If alive, give age *73* years

8. AGE: Years *66* Months *10* Days *8* If less than one day
hrs. min.

9. Birthplace *Old Forge, Va.*
(Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business *Iron house*

12. Name *Ash*

13. Birthplace *Va.*

14. Maiden name *Jennie Chapman*

15. Birthplace *Va.*

16. Informant *Robert Claude Walter*
Address *2106 Oak Rd. Sparrows Pt. Balt. Md.*

17. *Burial* Date thereof *Oct. 10-48*
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory *Oak Lawn Cem.*

Location *Eastern Ave.*

18. Funeral director *John F. Miller*
Address *2334 Jefferson St.*

19. *10/8* *45* *A. H. Hedrick*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 7, 1945* at *8:30* A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *July* 19 *28* to *Oct. 7* 19 *45*
and that I last saw him alive on *Oct. 6* 19 *45*

Immediate cause of death *Myocardial*
decompensation

DURATION

3 days

Due to *Hypertensive*

Due to *Cardiovascular*

disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Louis D. Pollie, M.D.*
Address *Sparrows Point* Date signed *10/7/45*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 756

CERTIFICATE OF DEATH

09887

Reg. Dist. No. 57

1. PLACE OF DEATH:

County BaltimoreCity or town Lutherville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Lutherville
(If outside city or town limits, write RURAL and give nearest town)Street No. Burton Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edna Powell Washburn

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

H. Homer Washburn

7. Birth date of deceased (mo., day, yr.)

Jan 20, 19066. (c) If alive, give age 36 years

8. AGE:

Years

Months

Days

If less than one day

3995

hrs.

min.

8. Birthplace

Virginia
(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

FATHER

12. Name

John B. Savage

13. Birthplace

Virginia

14. Maiden name

Ettel West

15. Birthplace

Virginia

16. Informant

H. H. Washburn

Address

Lutherville Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 27, 1945
(month) (day) (year)

Cemetery or crematory

Greenmount

Location

Baltimore, Md.

18. Funeral director

Landen M. Brooks

Address

Sparks, Md.19. Oct. 26 45
(Date rec'd by registrar)

19.

Wilmer C. Ensor

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1945 at 3:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-7 1941 to 10-25 1945and that I last saw him/her alive on 10-25 1945

Immediate cause of death

decompensation
Cardiac failure

DURATION

Due to

Pneumonic heart disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bennett C. Starn
M. D. or other
Address Lutherville Date signed 10/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECORDED
OCT 30 1945
BOSTON & F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, MarylandHow long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 6009 Highgate Drive
(If rural, give LOCATION)2.(a) If veteran, name war WW-2 ✓

3. (a) FULL NAME

HERBERT J. WEAVER

3. (b) Social Security Number

217-07-0381

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Margaret R. Weaver7. Birth date of deceased (mo., day, yr.) 8-18-16 6. (c) If alive, give age _____ years8. AGE: Years 29 29 Months 1 Days 29 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name James R. Weaver13. Birthplace Illinois14. Maiden name Regina Abendschoen15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. Fac.Address Fort Howard, Maryland17. Burial Date thereof 10/20/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryBaltimore, Maryland

Location

18. Funeral director William Cook, Inc.Address St. Paul & Preston Sts. Balto. Md.19. Oct 19 19 45 AW Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1945 at 7:40 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3 1945 to October 17 1945and that I last saw him alive on October 17 1945Immediate cause of death Nephritis, parenchymatous, chr.DURATION
2 Yrs.
plus

Due to

Due to

Other conditions Anemia, secondary UnknownHypertension, both due to above 1 Yr.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lou Ann BalterA. M. BALTER, LT. COL., MCG. GEN. DIR.
Address Fort Howard, Md. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore *33*

Reg. Dist. No. *44*

CERTIFICATE OF DEATH

09889

1. PLACE OF DEATH:

(a) County *Baltimore*
 (b) City or town *Essey*
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution:
430 Virginia Ave.
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State *Md.* (b) County *Balto.*
 (c) City or town *Essey*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *430 Virginia Ave.*
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME

John Wiegman Jr.
 3 (b) If veteran, name war _____ 3 (c) Social Security
 No. *213-07-9107*

4. Sex *m.* 5. Color or race *W.* 6 (a) Single, married, widowed, or divorced *married*

6 (b) Name of husband or wife *Rose Wiegman*
ne Mrowczynska 6 (c) If alive, give age *42* years

7. Birth date of deceased (mo., day, yr.) *Oct. 10 - 1901*

8. AGE: Years *44* Months *0* Days *11* If less than one day
 _____ hr. _____ min.

9. Birthplace *Baltimore*
 (Town, county, and state)

10. Usual occupation *Roller maker*

11. Industry or business *Harbor Pt. Shipyard*

12. Name *John Wiegman Jr.*

13. Birthplace *Maryland*

14. Maiden Name *Julia Evers*

15. Birthplace *Maryland*

16 (a) Informant *Mrs. Rose Wiegman*

(b) Address *430 Virginia Ave.*

17 (a) *Burial* (b) Date thereof *Oct. 24 - 45*
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Morland Park*

Location *Taylor Ave.*

18 (a) Funeral director *John G. Connolly*

(b) Address *Crestmont*

19 (a) *Oct. 22 - 45* (b) *John G. Connolly*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. Date of death *Oct. 21* 19*45*, at *7:10 A.* M

21. I certify that death occurred on the date above stated; that I attended deceased from *July 1* 19*45*, to *Oct 21* 19*45*, and that I last saw him alive on *Oct 21* 19*45*.

Immediate cause of death *Coronary Thrombosis* Duration *Sudden*

Due to *arteriosclerosis*

cardiac vascular disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature *W. M. Baumgardner*

M. D. or other _____

Address *Balto 6* Date signed *10/21/45*

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 23 1945
BUREAU

PLEASE-WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH: County..... <u>BALTIMORE</u> City or town..... <u>GLENN ARM.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>7 MONTHS</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>MD</u> County..... <u>KENT</u> City or town..... <u>CHESTERTOWN</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....											
3. (a) FULL NAME <u>AMY B. WILKINS</u>				3. (b) Social Security Number											
4. Sex <u>F</u>				5. Color or race <u>W.</u>											
6.(a) Single, married, widowed, or divorced <u>Widowed</u>				6.(b) Name of husband or wife <u>Wm. Wilkins</u>											
7. Birth date of deceased (mo., day, yr.) <u>NOV 29, 1880</u>				8.(c) If alive, give age years											
8. AGE: <table border="1"> <tr> <td>Years</td> <td>Months</td> <td>Days</td> <td>If less than one day</td> </tr> <tr> <td>64</td> <td>11</td> <td>1</td> <td>..... hrs. min.</td> </tr> </table>				Years	Months	Days	If less than one day	64	11	1 hrs. min.	9. Birthplace <u>BALTIMORE CO. MD.</u> (Town, county, and state)			
Years	Months	Days	If less than one day												
64	11	1 hrs. min.												
10. Usual occupation <u>Housewife</u>				11. Industry or business											
12. Name <u>LORENZO LOCHARD</u>				13. Birthplace <u>MD</u>											
14. Maiden name <u>MARZARET CARR.</u>				15. Birthplace <u>MD</u>											
16. Informant <u>MRS. EDW. WELLS</u> Address <u>Glenn Arm. Maryland</u>				17. (Burial, cremation, or removal. Which?) <u>Cremation</u> Date thereof <u>Nov. 2 1945</u> (month) (day) (year) Cemetery or crematory <u>SILVER BROOK CREMATORY</u> Location <u>Wilmington Delaware.</u>											
18. Funeral director <u>J. Willis Wells</u> Address <u>Chestertown, MD</u>				19. (Date rec'd by registrar) <u>OCT. 30 1945</u> <u>G. E. Arthur</u> Registrar											
MEDICAL CERTIFICATION															
20. DATE OF DEATH <u>October 30 1945</u> at <u>4:30 P.</u>															
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from <u>October 30 1945</u> and that I last saw him alive on <u>Oct. 30 1945</u>															
Immediate cause of death <u>Coronary Thrombosis</u>															
DURATION															
Due to															
Due to															
Other conditions															
(Include pregnancy within 3 months of death)															
Major findings of operations															
Date of op.															
Autopsy results															
PHYSICIAN: Please underline the cause to which death should be charged statistically.															
22. VIOLENCE: If death was due to external causes, fill in the following:															
Accident, suicide, or homicide..... Date of.....															
Where did injury occur? (City or town) (County) (State)															
Injured at home, farm, industry, public place (where?)															
Means of injury Injured at work?															
23. SIGNATURE <u>Clifford F. Hudson, MD</u> <u>York, MD</u> M. D. or other Address..... Date signed <u>10/30/45</u>															

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY

HEALTH SERVICES ADMINISTRATION

1000 ...

1000 ...

RECEIVED
NOV 3 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County BaltimoreCity or town Crowns Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Reuben James Williams

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Williams

7. Birth date of deceased (mo., day, yr.)

July 4 - 1877

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

68318hrs.min.

9. Birthplace

Baltimore Co. Maryland

(Town, county, and state)

10. Usual occupation

Truck Farmer

11. Industry or business

FATHER

12. Name

Abraham Williams

13. Birthplace

Pennsylvania

MOTHER

14. Maiden name

Barrett White

15. Birthplace

England

16. Informant

Mrs. Mary Williams

Address

Caves Road, Crowns Mills

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 10 - 22 - 1945

(Date rec'd by registrar)

Dr. E. E. Nichols
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore

City or town

Crowns Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Caves Road

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 22 - 1945 at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 26 1941 to Oct 22 1945and that I last saw him alive on Oct 21 1945

Immediate cause of death

Wrenie Poisoning

DURATION

3 days

Due to

Malaria

Due to

arterial hypertension and other diseases

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. E. Nichols M.D.

M. D. or other

Address

Pikesville - 8thDate signed Oct 22 - 45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09891

RECEIVED
OCT 24 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County BaltimoreCity or town Halethorpe
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County alleganyCity or town Barton
(If outside city or town limits, write RURAL and give nearest town)Street No. 5728 First Ave
(If rural, give LOCATION) ✓

2.(a) If veteran, name war

3. (a) FULL NAME

Williamina Caroline Williams

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Married

8.(b) Name of husband or wife

George Ellsworth Williams8.(c) If alive, give age 81^{mo.} years

7. Birth date of deceased (mo., day, yr.)

Feb 6 - 1864

8. AGE:

Years

81

Months

10

Days

23

If less than one day

.....hrs.min.

9. Birthplace

Barton md.
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Housewife

FATHER

12. Name

Henry Schramm

13. Birthplace

West Virginia

MOTHER

14. Maiden name

Christina Reppel

15. Birthplace

Warttemberg Germany

16. Informant

Mrs. Matthe's daughter

Address

5728 - 1st Ave Halethorpe 27 - md

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

Nov. 1 - 45
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

Geo E. Bahr, Jr.
601 E. Baltimore St.

19.

Oct 29 1945
(Date rec'd by registrar)Oct 30 1945
DeLoeff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1945, at 5:25 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1945, to Oct 29 1945, and that I last saw him alive on Oct 28 1945.

Immediate cause of death

Acute dilatation of the heart

Due to

Ch. Myocarditis 2 yrs
Ch. Chaperation 6 mo.

Due to

General arteriosclerosis

Other conditions

Sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

none

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. B. Brewbrough
8609 Main St.
Edgewater md.

M. D. or other

Address..... Date signed 10/29/45

MADE IN THE STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

ALBANY COUNTY

35

RECEIVED
NOV 2 1945
BUREAU V.R.

2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 892

CERTIFICATE OF DEATH

09893 42
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1608 Linden Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1608 Linden Lane
(If rural, give LOCATION)2.(a) If veteran, name war. 10

3. (a) FULL NAME

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Richard A. D.

7. Birth date of deceased (mo., day, yr.)

Dec 30, 1893

8. AGE:

Years 74 Months 9 Days 14 If less than one day9. Birthplace West Union W. Va
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Michael P. Donohue13. Birthplace England14. Maiden name Clara Walker15. Birthplace England16. Informant Dorothy J. WillisAddress 1608 Linden Lane Baltimore17. (Burial, cremation, or removal) Which? Burial Date thereof 10/18/45
(month) (day) (year)Cemetery or crematory NationalLocation Baltimore Md18. Funeral director William J. JonesAddress 1217 St Paul St19. 10/16 45 A. W. Hedrick
(Date rec'd by registrar) (year) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 19 45, at 89 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 35, to Oct 14 19 45and that I last saw h. or alive on Sept 19 45Immediate cause of death Cerebral accidentprobable cause of death17th - EpilepsyDue to Hypertension w. apoplexyDue to 2Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frederick B. BrierAddress Medical Arts Bldg BaltimoreDate signed Oct 14 45

CERTIFICATE OF DEATH *131-2*Registered No. *09894*

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *616 PLYMOUTH ROAD*
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *✓*
 (e) Length of stay in Baltimore (yrs., mos., or days) *70 YRS*

3 (a) FULL NAME

ROBERT WESLEY WILSON

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. *NONE*

4. Sex *MALE* 5. Color or race *WHITE* 6 (a) Single, married, widowed, or divorced *SINGLE*

6 (b) Name of husband or wife
 6 (c) If alive, give age *✓* years

7. Birth date of deceased (mo., day, yr.) *MAY 11-1861*

8. AGE: *84* Years *5* Months *17* Days If less than one day
 hr. min.

9. Birthplace *HOWARD COUNTY, MD.*
(Town, county, and state)10. Usual Occupation *RETIRED PARK POLICE*11. Industry or business *POLICE DEPT.*12. Name *ROBERT WILSON*13. Birthplace *BALTIMORE, MD.*14. Maiden Name *AGNES SPENCER*15. Birthplace *ENGLAND*16 (a) Informant *JACOB H. DORRIER*(b) Address *616 PLYMOUTH ROAD*

17 (a) *BURIAL* (b) Date thereof *OCT-27-1945*
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *WESTERN CEMETERY*
 Location *EDMONDSON AVENUE*

18 (a) Funeral director *G. LESTER WEBER*(b) Address *7503 EDMONDSON AVE.*

19 (a) *26 1945* (b) *Huntington Williams MD*
 (Date rec'd by registrar) (Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County
 (c) City or town *BALTIMORE*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *616 PLYMOUTH ROAD*
 (If rural give location)
 (e) Citizen of foreign country? *NO* (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *OCT 23* 19 *45*, at *9:00 P.* M.

21. I certify that death occurred on the date above stated; that I attended deceased from *May* 19 *45*, to *OCT 23* 19 *45*, and that I last saw him alive on *OCT 23* 19 *45*.

Immediate cause of death *Cardio-Vas. Renal Disease*
 Duration *4 yrs.*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature *A. P. Van Schuyndael MD*

Address *4818 Edmondson* Date signed *10/24/45*
 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **3089**

00895

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: *Edmondson Ave. - Nursery Ave.*

(c) Hospital or institution: *Coptic Nursing Home*

(d) Length of stay in hospital or inst. (yrs., mos., or days) *3 mos. 7 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *1/8*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town: *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *22 East in St.*

(If rural give location)

(e) Citizen of foreign country? *Perkin*

If yes, name country

(Yes or No) *✓*

3 (a) FULL NAME

3 (b) If veteran, name war

3 (e) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female

White

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Dec 12, 1871*

8. AGE: Years *73* Months *12* Days *10* If less than one day hr. min.

9. Birthplace *Baltimore Md.*

(Town, county, and state)

10. Usual Occupation *house work*

11. Industry or business *at home*

FATHER 12. Name *Geo. Berneburg*

13. Birthplace *Germany*

MOTHER 14. Maiden Name *Mary C. Berneburg*

15. Birthplace *Germany*

16 (a) Informant *Mrs. Elizabeth B. B. B. B. B.*

(b) Address *1135 S. Calver Street*

17 (a) *None* (b) Date thereof *10-25-1945*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Union Cemetery*

Location *in ground - Edmondson Ave.*

18 (a) Funeral director *Wm. C. Brown*

(b) Address *441 E. 3rd St.*

19 (a) *Oct. 24, 1945* *A. W. Hedrick*

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 22, 1945* at *3:10* P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 20, 1945* to *Oct. 21, 1945*, and that I last saw him alive on *Oct. 21, 1945*.

Immediate cause of death

acute myocardite

Duration

Due to *acute myocardite*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury *water 3 square*

23. Signature *John J. Hedrick*

Address *4012 Edmondson*

Date signed *Oct 24, 1945*

M. D.

Registrar

Rev. D.M.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

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For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

09896

★ Reg. Dist. No. 42

1. PLACE OF DEATH:

County Balto.City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5300 New Edmondson Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 5300 New Edmondson Blvd.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

WILLIAM WINFIELD WOLTER

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Gladys Y. Wolter

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

April 4, 1906

8. AGE:

Years

Months

Days

If less than one day

39626

..... hrs.

..... min.

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation Building Supplies

11. Industry or business

Self12. Name Andrew H. Wolter13. Birthplace Pa.14. Maiden name Mary Thompson15. Birthplace Virginia16. Informant Mrs. Gladys Y. WolterAddress 5300 New Edmondson Blvd.17. Burial
(Burial, cremation, or removal. Which?)

Date thereof

11/2/45

(month) (day) (year)

Cemetery or crematory Rock Creek Cem.Location Washington, D. C.18. Funeral director C. Howard Tickner, Sr.Address North & Pa. Aves., Balto., Md.19. Oct 31 45
(Date rec'd by registrar)Ger Kieffer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1945, at 8:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death.....

DURATION

Coronary Occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address 1010 Leeds Ave Date signed 10-30-45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF TEXAS

RECEIVED

NOV 2 1945

BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Baltimore
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 59 days
 Hospital, institution, or street address where death occurred:
Harlem Lodge
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Johns
 City or town... LAYTONSVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Helen JAMES WORLEY

3. (b) Social Security Number

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1877 6. (c) If alive, give age..... years

8. AGE: Years 68 Months 7 Days 27 If less than one day..... hrs. min.

9. Birthplace... Balto. Md.
 (Town, county, and state)

10. Usual occupation... retired school teacher

11. Industry or business

12. Name... Mrs. James Worley

13. Birthplace... Balto. Md.

14. Maiden name... Mrs. M. Waters

15. Birthplace... Md.

16. Informant... Mrs. W. Worley

Address... 2624 St. Paul St.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 10/20/45
 (month) (day) (year)

Cemetery or crematory... Louisa Park

Location... Frid. Ave. Balto. Md.

18. Funeral director... John O. Mitchell & Sons

Address... 1900 Eutaw Place

19. 1079 45 10/20/45
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 17 1945 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 1945 to October 17 1945 and that I last saw her alive on October 17 1945

Immediate cause of death... CARDIAC FAILURE
ACUTE DURATION 30 min

Due to... ARTERIOSCLEROSIS - general years

Due to... MAJNUTRITION 3 mos

Other conditions... SENIOR PSYCHOSIS 6 mos
 (Include pregnancy within 8 months of death)

Major findings of operations... Date of op.

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Arthur J. McCalland, MD
Harlem Lodge M. D. or other
Catonsville, Md. Address... Date signed 10-17-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

09898

9

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Balto.City or town Brooklandville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Ruxton Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Brooklandville
(If outside city or town limits, write RURAL and give nearest town)Street No. Ruxton Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHNSON PEARCE WRIGHT

3. (b) Social Security Number

216-10-2262

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Adele Shipley Wright

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Aug. 1, 1878

8. AGE:

Years

Months

Days

If less than one day

67

2

26

..... hrs. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)10. Usual occupation President11. Industry or business Rockland Bleach Dye Co.12. Name Robert Wright13. Birthplace Balto. Co., Md.14. Maiden name Mary E. Pearce15. Birthplace Balto. Co., Md.16. Informant Mrs. Adele S. WrightAddress Ruxton Rd., Brooklandville, Md.17. Burial Date thereof 10/30/45
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Druid Ridge Cem.
Pikesville, Md.

Location

18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 10/30/45 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1945 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1, 1944 to Oct 25, 1945
and that I last saw him alive on Oct 25, 1945

Immediate cause of death

DURATION

Coronary Occlusion acuteDue to arteriosclerosisDue to hypertension acute

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm J Tickner M.D. or otherAddress Baltimore - Md Date signed 10/29/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 09835

1. PLACE OF DEATH:

County BaltimoreCity or town Monkton, Ind

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ella Mary Gager

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Henry D. Gager6. (c) If alive, give age 76 years

7. Birth date of

deceased (mo., day, yr.) July 21 - 1879

8. AGE:

Years

Months

Days

If less than one day

66213

hrs.

min.

9. Birthplace

Monkton, Iowa

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Albert T. Kephart

13. Birthplace

Iowa

MOTHER

14. Maiden name

Catherine K. Smith

15. Birthplace

Iowa

16. Informant

Mrs. Guendalyn Beckling

Address

Monkton, Ind17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct 8 - 45
(month) (day) (year)

Cemetery or crematory

Monkton, Ind

Location

Monkton, Ind

18. Funeral director

Howard S. Mahler

Address

White Hall, Ind19. Oct. 8,

(Date rec'd by registrar)

19 45Mrs. Howard S. Mahler

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State IndCounty RandolphCity or town Moscow, Indiana

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 419 45

at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 419 45

to

Oct. 4 19 45

and that I last saw her alive on

Oct. 419 45

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to

Due to

Other conditions

Hy pertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. M. France

M. D. or other

Address

Parletown, Ind.

Date signed

10/6/45

CERTIFICATE OF DEATH

1. Full Name of Deceased

2. Date of Death

3. Medical Certification

RECORDED
OCT 9 1946
BUTLER & B